Certificate of Fitness

PART ONE – To be completed by the examining medical practitioner

Full name of the Contestant: _____

Address: _____

Suburb: _____ State: _____ Post Code: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

I certify that this person is **FIT / UNFIT** *(delete one)* to compete or participate in a combat sports contest.

Signed: _____ Print Name: _____

Medical Practitioner *Medical Practitioner*

Provider Number: _____ Date: _____/_____/_____

Medical practitioner's stamp:

Executive Officer,
Combat Sports Commission
Department of Local Government, Sports and Cultural Industries
PO Box 8349, Perth Business Centre, WA, 6849
Phone: 08 6552 1604
Fax: 08 6551 9359
Email: combatsport@dlgsc.wa.gov.au
ABN: 85 243 853 379

PART TWO – Medical and Competition History

Division 1 – Personal Details and Competition History *(To be completed by the CONTESTANT)*

Please use BLOCK LETTERS

FAMILY NAME	GIVEN NAMES	EXAMINATION DATE
RESIDENTIAL ADDRESS		POST CODE
HOME PHONE	MOBILE	
DATE OF BIRTH (dd/mm/yyyy)	GENDER ☐ MALE ☐ FEMALE	

1. CAREER HISTORY

Career Results	Wins	Losses	Draws
Amateur			
Professional			

2. HAVE YOU SUFFERED ANY INJURIES WHILE COMPETING? ☐ YES ☐ NO

3. HAVE YOU HAD ANY HEADACHES, VOMITNG OR PROBLEMS WITH SPEECH OR VISION AFTER A CONTEST? ☐ YES ☐ NO

Division 2 – Medical History

(To be completed by the MEDICAL PRACTITIONER)

		Yes	No			Yes	No			Yes	No
1.	Have you at present any: a. illness b. disability			13.	Tuberculosis			26.	Hepatitis or other jaundice Liver disease		
2.	Are you now receiving medicine, drugs, or other treatment			14.	Asthma Other lung disease			27.	Rupture Hernia Swollen /painful testicles		
3.	Has an accident or illness kept you off work for more than one week			15.	Deafness Tinnitus			28.	Any skin trouble Tendency to bruise or bleed easily		
4.	Have you ever had any operations			16.	Visual problems Do you wear glasses or contact lens			29.	Concussion Severe head injury Loss of consciousness		
5.	Have you ever been a patient in any hospital: a. Medical b. Other			17.	Fainting attacks Blackouts			30.	Knee injury Ankle injury Back injury Other joint injury or dislocation		
Have you ever had or are you now suffering from any of the following?				18.	Fits or convulsions Epilepsy Giddiness			31.	Fractured bones Chipped bones		
6.	Rheumatic fever Heart disease			19.	Severe headaches Migraines			32.	Paralysis (including polio)		
7.	Palpitations or pounding heart			20.	Nervous trouble Severe depression Mental illness Attempted suicide			33.	Any other injury, illness or disability		
8.	High or low blood pressure			21.	Kidney disease Bladder disease Pain passing urine Blood in your urine			34.	**(Females)** Are you pregnant?		
9.	Swollen or painful joints (other than through injury)			22.	Frequent indigestion						
10.	Shortness of breath			23.	Ulcer of stomach Ulcer of duodenum						
11.	Pneumonia Bronchitis or pleurisy			24.	Gall bladder trouble Gall stones						
12.	Coughing blood Coughing up phlegm			25.	Sugar diabetes						

Medical Practitioner's Notes on History

(A 'Yes" answer to any question requires the medical practitioner to state the question number and comment here)

35. Over the past five (5) years has the Contestant, either occasionally or regularly, taken any stimulants, sedatives, medications or drugs by mouth or by injection?

☐ YES ☐ NO

If 'Yes", provide details and, if prescribed by a doctor, include the relevant particulars in question 36 below.

36. Over the past five (5) years has the Contestant had any medical examination, advice, treatment or been in hospital?

☐ YES ☐ NO

If 'Yes", provide particulars of each instance (including x-ray, electrocardiogram or other special tests) in the table below.

Date	Name and address of doctor and/or hospital	Reason (If illness or injury, give duration and date of recovery)

37. Details of photographic identification provided to the medical practitioner:	Drivers Licence #	Passport #

PART THREE – Record of Medical Examination prior to Registration/Renewal of Registration

(To be completed by the MEDICAL PRACTITIONER)

	Physical Examination	Normal	Abnormal		Physical Examination	Normal	Abnormal
1.	a. Head, face, scalp b. Neck R.O.M.			16.	Ophthalmoscopic examination		
2.	a. Nose deformity b. Nose airway			17..	Chest, lungs		
3.	a. Mouth, throat b. Speech			18.	Heart (if ECH performed, note result in section & enclose F MED 53)		
4.	a. Teeth, gums b. Dentures Yes / No			19.	Vascular system (include veins)		
5.	a. Ears – general b. Ears – hearing			20..	Abdomen (include hernial orifices)		
6.	Tympanic membranes			21.	Endocrine system		
7.	Eustachian tubes			22.	External genitalia		
8.	Eyes – general			23.	a. Feet b. Limbs R.O.M. c. Gait		
9.	a. Visual fields b. Eye gaze			24..	A. Spine b. Trunk R.O.M. c. Posture (standing)		
10.	Eye movement			25..	a. Nervous system b. Cranial nerves		
11.	a. Cerebellum function b. Body balance/ coordination			26..	Height: (cm)		
12..	a. Muscle tone b. Muscle strength c. Sensation			27.	Chest: (cm) Exp Ins		
13..	Reflexes			28..	Waist: (cm)		
14..	Skin			29..	Urinalysis: Albumin Sugar		
15..	Lymphatic system Lymph glands in neck axillae or inguinal			30..	Current weight: (kg) Previous contest weight/class: (kg) date: Proposed contest weigh/class: (kg) date:		

31..	Emotional stability			35.	Blood Pressure: Systolic Diastolic
32..	Other			36.	Eye Colour:
33.	Identifying marks			37.	Distant vision: R6 Corr 6 L6 to 6 Near vision: ☐ Normal ☐ Abnormal
34.	Frame: Large Medium Small			38.	Has a MRI Scan been conducted? ☐ Yes ☐ No Is the MRI satisfactory? ☐ Yes ☐ No Any further testing required? ☐ Yes ☐ No **Please attach a copy of the radiologist's report.**

39. Medical Practitioner's Notes on Medical Examination
(Provide details of any abnormality noted and enter the relevant question number before each comment.)

40. Is any further testing required? ☐ YES ☐ NO

Neuro/Psychological Examination

41.	Is there any evidence of a change in character?	☐ YES ☐ NO
42.	Has the contestant a good memory for recent events and, in particular, recent contests?	☐ YES ☐ NO
43.	Does the contestant follow conversation with attention and intelligence?	☐ YES ☐ NO
44.	Is there any evidence of a tendency to violence outside the competitive arena?	☐ YES ☐ NO

45. Medical Practitioner's Notes on Neuro/Psychological Examination
(State whether further assessment is required.)

46. Particulars of any Disabilities

Contestant/Participant's Declaration and Release of Medical Information Authorisation

I declare that the information provided in this Certificate of Fitness is true and complete to the best of my knowledge and belief.

I authorise (*insert name of MEDICAL PRACTITIONER*) _____ to provide personal medical information to the Western Australian Combat Sports Commission for administering the *Combat Sports Act 1987* and authorise the medical practitioner to obtain details of my medical records from previous medical practitioners if required.

Contestant/Participant name (*print*) _____Signed _____Date__/__/__

I have completed the above Medical History and have witnessed the contestant/participant signature.

Medical Practitioner name (print) _____Signed _____Date __/__/__

Medical Practitioners Summary

Name of examined Contestant _____

Do you consider the Contestant to be fit to participate as a Contestant in combat sports contests?

☐ YES ☐ NO ☐ Further Assessment Required

Any comments: _____

_____

Date _____/_____/_____

Signature of medical practitioner _____

Name of medical practitioner *(please print)*_____