



ICNZ MMA

(Form B)

MEDICAL CLEARANCE

Name: _____

D.O.B.: ____/____/____

Address: _____

Phone: A.H. _____ B.H. _____

Mobile: _____

Fax: _____

email: _____

Have you previously or do you currently suffer from.....

	Yes	No		Yes	No
Fainting			Severe head aches		
Deafness			Migraine head aches		
Concussion			Pneumonia, tuberculosis		
Paralysis			Joint injury/disability		
Sight problems			Renal or Bladder disease		
Rheumatic fever			Asthma		
Nervous disorder			Mental illness/ disability		
Diabetes			Heart disease/ condition		
Fractures or breaks			High/low blood pressure		
Epilepsy			Any other injury/disorder		

Detailed explanation if you ticked yes to any of the above:

Examination:

Weight (kgs):

Height (cms):

Pulse:

Blood pressure:

Examination: Mark 'N' for Normal, 'A' for Abnormal

Head	Eyes	Visual field	Upper extremities
Face	Ears	Eye movement	Lower extremities
Neck	Hearing	Tympanic membranes	Posture (standing)
Scalp	Lungs	Eustachian tubes	Nervous system
Nose	Heart	Vascular system	Lymphatic system
Chest	Skin	Abdomen	Emotional stability
Mouth	Feet	Endocrine system	Mental capacity
Teeth	Spine	Gums	Gait

EXAMINER'S COMMENTS

Serology for HIV, Hep A, B & C (Dr. to tick which box applies)

- Bloods taken on this day
- Serology results obtained less than six months ago (results available)

A copy of the Bloods Report to be submitted at weigh in.

I, (doctors name) _____
 have examined (participants name) _____ on this day and found
 them medically fit to participate in an Amateur Mixed Martial Arts contest to be
 held on the _____ of _____ at the Auckland Boxing Association:

Doctors Name: _____ **Phone:** _____

Address: _____

Signature of Examining Doctor: _____ **Date:** _____

RELEASE OF INFORMATION

I, (participants name) _____ authorise the release of all information contained in this report to ICNZ and its Officers

Signed: _____ Date: _____