Physician’s PRE/POST Bout Exams
Boxing/MMA/Kickboxing/Elimination Tournaments

Athlete Legal Name: ___________________________________________ Event Date: ____________

Last  First  Middle

RR: __________  BP: __________/__________  HR: __________

Normal  Abnl
Alertness/Orientation  □  □  Heart (Rhythm/sounds)  □  □  Romberg/Pronator Drift  □  □
Head/Periorbital/CN’s  □  □  Chest/Lungs/Ribs  □  □  Finger to Nose  □  □
PERRLA/EOMI/Vision  □  □  Abdomen  □  □  Knuckle Push Ups  □  □
Jaw/Oropharynx/Teeth  □  □  Upper Extremities  □  □  Tandem Gait  □  □
Nose (stability/obstruction)  □  □  Lower Extremities  □  □  Duck Walk  □  □
Ears/Hearing (grossly)  □  □  Hands/Wrists  □  □  Crab Walk  □  □
Neck  □  □  Skin (rashes, infxns)  □  □  Other: __________  □  □

(Women only) Pregnancy test- Urine/Serum (check one): □ Negative  □ Positive (Automatic DQ)

Abnormalities:
__________________________________________________________

Based on the statements made by the athlete, the Medical History form and my physical findings it is opinion this athlete  □ IS  □ IS NOT in good physical condition and able to compete in boxing/MMA/kickboxing/elimination tournament.

Reason if not cleared for competition:
__________________________________________________________

Physician’s Name, M.D/D.O.  ____________________________  Signature  ____________________________
License No.  ____________________________  Date  ____________________________

Physician’s Post Bout Evaluation

□ Won  □ Lost  Via:  □ KO  □ TKO  □ Draw  □ DQ  □ NC  □ Choke  □ Submission

Length of Suspension:  □ 14 days  □ 21 days  □ 30 days  □ 60 days  □ 90 days  □ Indefinite  Time of initial evaluation: ____________
Fighter Stable:  □ Yes  □ No  RR: __________  BP: __________/__________

Normal  Abnl
Alertness/Orientation  □  □  Jaw/Oropharynx/Teeth  □  □  Hands/Wrists  □  □
Head/Periorbital/CN’s  □  □  Neck  □  □  Skin (Lacerations)  □  □
PERRLA/EOMI/Vision  □  □  Heart/Lungs  □  □  Gait/Motor (grossly)  □  □
Ears/Hearing (grossly)  □  □  Chest/Ribs/Abdomen  □  □  Neuro (grossly)  □  □
Nose (stability/obstruction)  □  □  Extremities  □  □  Other: __________  □  □

Abnormalities:
__________________________________________________________

Mechanism of Injury/Diagnoses:
__________________________________________________________
Advised to report for second evaluation in: □ 15 □ 30 minutes □ Athlete failed to report for second evaluation

Results/time of seconds evaluation:

Recommended Medical Attention:
□ CT scan of brain □ CT scan: __________________________ □ X-Ray: __________________________

Examination/Follow up by: □ Ophthalmologist □ Neurologist □ Orthopedic doctor □ Primary care physician □ Other: __________________________

□ Referred to Emergency Department at: __________________________ □ Boxer refuses advice of physician

Comments: ____________________________________________________________________________________________________________________________________________________________

______________________________________________________________________________________________

Physician’s Name, M.D/D.O. __________________________ Signature __________________________ License No. __________________________ Date __________________________