



Head Quarters: 11320 Kiley Dr, Huntley, IL 60142

<https://wakousa.rsportz.com/memberships>

**AMATEUR ATHLETE PHYSICAL EXAMINATION KICKBOXING**

*Only a licensed physician may conduct this examination and complete this form.*

*Please complete this form in its entirety.*

**NOTE TO PHYSICIAN: PLEASE EMAIL COMPLETED FORM TO [elenajojola@gmail.com](mailto:elenajojola@gmail.com)**

Last Name,    First Name,    Middle Name		
<b>Address:</b> Street (No PO BOX) City State Zip Code Country		
Telephone number: Email:		
<b>Male / Female</b> (circle one)	Age:	Date of Birth: (MM / DD / YYYY):
<p><b>PHYSICAL HISTORY:</b> Please check all that applies below: Asthma, Blood in urine, Allergies, Fainting spells, Rupture (hernia), Chest pains, Operations, Shortness of breath, Swollen joints, Rheumatism, Diabetes, Frequent headaches, Convulsions (fits), Chronic cough, Spitting of blood, Cerebral hemorrhage, or serious head injury. If yes, please explain: _____</p> <p>_____</p> <p><b>When was the last time you took any type of medication or drug? (State what type and when and be specific):</b></p> <p>_____</p> <p><b>Have you ever undergone any type of surgery? Yes No (State what type and when and be specific):</b></p> <p>_____</p> <p><b>When was the last time you took any type of vitamin supplement? (State what type and when and be specific):</b></p> <p>_____</p>		
<b>Amateur Record:</b>  Kickboxing: W: ____ L: ____ Muay Thai: W: ____ L: ____  Boxing: W: ____ L: ____ MMA: W:: ____ L:: ____	<b>Comments:</b>	

# AMATEUR ATHLETE PHYSICAL EXAMINATION

APPLICANT NAME: \_\_\_\_\_

## PHYSICAL EXAMINATION:

General appearance: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Temperature: \_\_\_\_\_ Disabling scars: \_\_\_\_\_ Mouth: \_\_\_\_\_ Teeth: \_\_\_\_\_ Tonsils:  
\_\_\_\_\_ Neck: \_\_\_\_\_ Pulse at rest: \_\_\_\_\_ Pulse after 100 hops: \_\_\_\_\_  
Blood pressure at rest: \_\_\_\_\_ After 100 hops: \_\_\_\_\_ 2 minutes later: \_\_\_\_\_ Enlarged glands: **Yes No**  
Goiter: **Yes No** Heart: Pulse rhythm (circle one) **Regular Irregular** Murmurs: **Yes No** Musculoskeletal system:  
\_\_\_\_\_

Apical impulse (circle one): **Heavy Normal** Enlargement: **Yes No** Lungs: Rales **Yes No**

Abdomen: Enlargement of liver **Yes No** Breasts: Mass **Yes No** Tenderness **Yes No**

Discharge **Yes No** Enlargement of Spleen: **Yes No** Hernia: **Yes No** Testicles: Normal **Yes No**

Remarks: \_\_\_\_\_

Reflexes: Pupils \_\_\_\_\_ Knee jerks \_\_\_\_\_ Romberg \_\_\_\_\_ Babinski \_\_\_\_\_

Skin: Tone \_\_\_\_\_ Rash \_\_\_\_\_ Boils \_\_\_\_\_ Other: \_\_\_\_\_ Unhealed wounds: \_\_\_\_\_

Remarks: \_\_\_\_\_

The information contained on this form is maintained by the World Association of Kickboxing Association at 11320 Kiley Dr, Huntley, IL 60142. All items of information are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application or result in your application being rejected as incomplete. The information provided will be used to determine your qualifications for licensure pursuant to Business and Professions Code Section 18640.

The information on your application may be transferred to other governmental or law enforcement agencies. You have the right to review records maintained on you by the WAKO Organization unless the records are identified as confidential information pursuant to the Public Records Act or are exempted by Section 1798.40 of the Civil Code. You may gain access to the information by contacting the World Association of Kickboxing Organization at the address above.

## EXAMINING PHYSICIAN:

Based on your personal observation and review of the test results and considering Commission rules, is it your medical opinion that this applicant is physically fit to be licensed and compete in combative sports? **Yes No**

If no, please explain: \_\_\_\_\_

\_\_\_\_\_  
LICENSED PHYSICIAN'S NAME (print) MEDICAL LICENSE NO. (Stamp)

\_\_\_\_\_  
ATHLETES NAME (print)

\_\_\_\_\_  
ATHLETES SIGNATURE

\_\_\_\_\_  
ADDRESS / CITY / STATE / ZIP CODE

\_\_\_\_\_  
TELEPHONE NO.

\_\_\_\_\_  
DATE/TIME

\_\_\_\_\_  
PERSON WHO ASSISTED'S NAME (print)

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
PERSON WHO ASSISTED'S SIGNATURE

