Head Quarters: 5425 Nectar Circle, Elk Grove, CA. 95757
Email: aquesada.iska.ca@gmail.com

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; aquesada.iska.ca@gmail.com

Last Name, First Name, Middle Name		
Address: Street (No PO BOX) City State Zip Code Country		
Telephone number: **Email:**		
Male / Female (circle one)	**Age:**	**Date of Birth:** **(MM / DD / YYYY):**

PHYSICAL HISTORY: 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: _____

_____

When was the last time you took any type of medication or drug? (State what type and when and be specific):

_____

Have you ever undergone any type of surgery? Yes No (State what type and when and be specific):

_____

When was the last time you took any type of vitamin supplement? (State what type and when and be specific):

_____

Amateur Record: Kickboxing: W: _____L: _____ Muay Thai: W: _____L:_____ Boxing: W: _____L: _____ MMA: W:: _____L:: _____	***Comments:***

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 ISKA California at 5425 Nectar Circle, Elk Grove, CA.95757. 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 ISKA 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 ISKA California 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**