Annual Medical Examination form
for IMMAF Youth U18 athletes

To be completed by a doctor licensed to practice medicine in your region

To be countersigned by athlete's parent or guardian

Competitor name

Competitor date of birth

/ / (DD/MM/YY)

Competitor national team

Date of examination

/ / (DD/MM/YY)

Examining Doctor name

Examining Doctor registration number

Examining Doctor email address

Examining Doctor correspondence address

This medical examination is completed without access to medical records and the information contained therein is as disclosed to me by the competitor **Indicate if applicable* X

(stamp here if available, else signature required below)

Medical Examination form ONLY valid with Examining Doctor's stamp above OR signature below

Doctor signature

MEDICAL HISTORY | Detail any hospital admissions, serious injury or illness (physical or mental) and chronic conditions including current status and if under specialist care. Please specifically enquire about headache; dizziness; mood problems; forgetfulness; double vision; back, nuchal or radicular pain

SURGICAL HISTORY | Detail any surgical procedures carried out, including ophthalmic or laser surgery

DRUG HISTORY | Detail use of any regular supplement or medication

ALLERGIES | Detail any allergies

FAMILY HISTORY | Detail any FH sudden cardiac death, dementia or parkinsonism

PHYSICAL EXAMINATION

cm	Height
kg	Weight | current
kg	Weight | 'walk around'
kg	Weight | competition class
bpm	Heart rate
mmHg	Blood pressure

VISUAL ACUITY

	Left eye	Right eye
Uncorrected	/	/
Corrected	/	/

Medical Examination form will NOT be accepted without UNCORRECTED visual acuity test results

SYSTEM

**Indicate if NORMAL*

Cardiovascular | Heart sounds? Added Sounds? Apex beat position?	X
Respiratory | Rib cage? Breath sounds vesicular? Wheeze?	X
Abdominal | Scars? Organomegaly?	X
Musculoskeletal | Back and neck movement? Upper and lower limb movements?	X
Ear, nose and throat | TMs normal? Whisper test for auditory acuity? Oropharynx? Loose teeth? Lymphadenopathy?	X
Neurological | Muscle weakness? Coordination? Tremor? Romberg? Cognitive impairment? Nystagmus?	X
Eyes | Pupils equal and reactive to light?	X

ABNORMALITIES / COMMENTS | Detail any abnormality in physical examination

PLEASE DETAIL BELOW ANY CONCERNS YOU MAY HAVE REGARDING THIS PERSON'S PARTICIPATION IN CONTACT SPORTS INCLUDING BOXING AND MIXED MARTIAL ARTS

Examining Doctor name

Competitor name

Examining Doctor signature

Date / /

**Indicate if notes attached* X

Parent or guardian name

Relationship to competitor

I confirm that I have Parental Responsibility for the competitor, and that both they and I consent to the information contained in this form being shared with IMMAF, and with any persons engaged in the safety and welfare of competitors in Mixed Martial Arts contests

Parent or guardian signature

Date / /

PLEASE NOTE: This form will NOT be accepted incomplete or unsigned!