FOR WOMEN:

Pregnancy Test: ______________________

Breast Exam: ______________________

Gynecological Exam: ______________________

PHYSICIAN COMMENTS:

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PHYSICAL HISTORY(CONTNUED):

Unconsciousness from any other sport or for any other reason:

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Sickle Cell Disease:

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Infectious Disease:

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DILATED EYE EXAMINATION MUST BE PERFORMED BY AN OPHTHALMOLOGIST

EYES	RIGHT	LEFT
Distant Vision:		
Light Reflex:		
Accommodation Reflex:		
Fundi:		
Cataracts:		

Wears Contact Lenses: ______________________

Has patient had blurred vision?
If yes, please detail: ______________________

Has patient had surgical procedures done to his/her eyes or the tissues around the eye?
If yes, please detail: ______________________

Has applicant ever had a retinal tear, retinal detachment, glaucoma, aphakia, or dislocated lens?
If yes, please detail: ______________________

Does patient have different size pupils?
If yes, please explain: ______________________

I certify that I have examined the above contestant on ______________ and have found nothing in his//her eye examination which would prohibit engaging in an professional combative sport competition.

Ophthalmologist Name (printed) ______________________

Ophthalmologist Signature: ______________________

Ophthalmologist Address: ______________ City: ______________ State: ______ Zip: ______

Office Phone: ______________________ Physician's License Number: ______________________

I hereby declare that the foregoing information is true, complete and correct. I understand that any misrepresentation may subject me to license revocation and applicable legal penalties.

Contestant's Signature: ______________________ **Date:** ______________

Contestant (PRINT NAME) ______________________