**MEDICAL EXAMINATION BY ATHLETE**

**PLEASE PRINT LEGIBLE**

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| **SECTION ONE - ATHLETE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Athlete Name: | | | | | | |  | | Last: | | | | | | | | | | | | | | | |  | First: | | | | | | | | | | | | | | | |  | | Middle: | | | | | | | |
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| Ring Name: | | | | | | | | | | | | | | |  | DOB: | | | | |  | | Month: | | | | | | | | |  | | Date: | | | |  | Year: | | | | | | | |  | | Age: | | | |
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| **SECTION TWO – MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Last Competition: | | | | | | | | | | | | | | Month | | | | | |  | Date | | | | | |  | Year | | | | |  | | Results | | Other | | | | | |  | | | | | | | | |
|  | | | | | | | | | | |  | | |  | | | | | |  |  | | | | | |  |  | | | | |  | |  | Won | | | | |  | | | | Lost | | |  | | Draw | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Have you ever been knocked unconscious? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Yes |  | | | No | | | | If **YES,** when? | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Are you **currently** suffering from anyof the conditions noted below?(check all that apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Yes |  | | | No | | | | Headaches | | | | | | | | | If **YES,** explain: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Yes |  | | | No | | | | Blurred Vision | | | | | | | | | | | If **YES,** explain: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
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|  |  | Yes |  | | | No | | | | Dizziness | | | | | | | | If **YES,** explain: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Have you **recently** suffered from any of the injuries noted below? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Yes |  | | | No | | | | Injury while training for this bout | | | | | | | | | | | | | | | | | | | | | | | | | If **YES,** explain: | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Yes |  | | | No | | | | Neck Injuries | | | | | | | | | | | | If **YES,** explain: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
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|  |  | Yes |  | | | No | | | | Spinal Injuries | | | | | | | | | | | | If **YES,** explain: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Have you consulted a doctor for any medical condition while training for this bout? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Yes |  | | | No | | | | If **YES,** explain: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. Have you been ill in any manner since your last examination? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Yes |  | | | No | | | | If **YES,** explain: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. Have you suffered from any accident or injury while training for this bout? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Yes |  | | | No | | | | If **YES,** explain: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. Have you contracted any type of “communicable disease” that may be harmful to you | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| or others? | | | | |  | | | | Yes | | | |  | | | | No | | | If **YES,** explain: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Do you wish to provide information regarding any current medical condition? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Yes | |  | | | | No | | | | If **Yes,** please provide: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **ATHLETE DECLARATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I declare under penalty of perjury under the laws of the Pascua Yaqui Tribe, that I have read the foregoing application and that all answers given are true and accurate. I understand that any misstatement of material fact in this application will constitute grounds for disciplinary action by the Pascua Yaqui Athletic Commission. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Athletes Signature: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | | | | |  | | | | |