



Attention Fighter,

Enclosed are the essential requirements for fighters participating in all ISKA-sanctioned events. We kindly request that you print this cover letter along with the provided physical form and present them to your physician for compliance with our regulations as per the New York State Athletic Commission:

Fighter Physical Examination:

Prior to your visit to the doctor's office, please ensure that you have diligently filled out the first page of the physical examination form. This section contains your comprehensive medical history, which the physician needs to review before proceeding with the examination on the subsequent pages. It is imperative that fighters complete this portion, as physicals lacking this information will not be accepted.

Bloodwork:

Every fighter is mandated to undergo three specific blood tests with negative results: HIV, **Hepatitis B Surface Antigen**, and Hepatitis C Antibody.

Submission Protocol:

As these medical documents maintain their validity for a duration of one year from the date of the results, we kindly request that you retain the original hard copy amongst your important records. To ensure preparedness, it is advisable to digitize them by either scanning or photographing for easy access when necessary. Furthermore, it is recommended to generate multiple copies of these documents, which a copy should be carried with you to every weigh-in for ISKA sanctioned events. During these events, you will be required to present these copies to the event's medical personnel, who will retain them for record-keeping purposes. Even if the promotion has requested prior submission of these documents, it remains a prudent practice to carry a copy with you to the weigh-ins.

Submission Deadline:

We emphasize that all medical documentation be completed no later than two weeks before your scheduled fight date.

Joe Wall
New York State Director
(315) 278-5560 | JoeWallUpstateISKA@gmail.com
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Physicians' Guidelines:

Please present this packet to your physician completing the medical examination.

Physical Examination:

- Please ensure that all sections of the physical examination form are comprehensively filled out. It is imperative to confirm that the fighter has diligently completed the initial page and that you, as the healthcare provider, have thoroughly reviewed their medical history before proceeding to the examination section.
- Kindly make it a point to clearly inscribe the fighter's name on each and every page of the physical examination document.
- Additionally, kindly date the physical examination form, accompanied by your professional signature, to denote the date of the examination.
- Please do not overlook the importance of marking the designated checkbox to officially confirm whether the fighter is deemed fit for participation. It is crucial to understand that a completed physical examination, on its own, does not conclusively determine the fighter's medical suitability, which is why the inclusion of this clearance box is imperative.

Bloodwork:

- Ensure that all fighters present negative blood test results for **HIV**.
- All fighters must provide negative blood test results for **Hepatitis B Surface Antigen**. Other tests, such as Hepatitis B Surface Antibody or Hepatitis B Envelope Antigen, do not meet our requirements. This test is mandatory for all fighters, regardless of prior immunization.
- All fighters must possess negative blood test results for **Hepatitis C Antibody**.

We appreciate your cooperation and commitment to ensuring the safety and health of our fighters. If you have any inquiries or require further clarification, please do not hesitate to contact us.

Sincerely,

Joseph W. Wall

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Front To be Completed by Fighter

Name of Event: _____ Date of Event: _____
 First Name: _____ Last Name: _____ DOB: _____ Male Female
 Street Address: _____ City: _____ State: _____ Zip: _____
 Country: _____ Phone: (_____) _____
 Email: _____
 Do you have a Health Insurance? yes no If so, with what company? _____

Medical History:

Have you ever had, or do you currently have any of the following conditions? Please check boxes of all that apply.

1. Blood Disorder or Anemia		19. Hepatitis	
2. Seizure or Convulsions		20. Diabetes	
3. Rheumatic Fever		21. Physical Impairment	
4. Asthma or Shortness of Breath		22. Skin Disease or Rash	
5. High Blood Pressure		23. Chronic Cough	
6. Heart Disease or Heart Murmur		24. Headaches	
7. Chest pain, discomfort, or pressure		25. Swollen Joint, Joint Injury, or Dislocation	
8. Tuberculosis		26. Sprain, Muscle or Ligament Tear, Tendonitis	
9. Marfan Syndrome		27. Severe muscle cramps	
10. Rheumatism or Arthritis		28. Neck or Spine disorder or instability	
11. Sickle Cell Disease or trait (in self or family member)		29. Spitting or Coughing of Blood	
12. Kidney, Lung, Testicle or Eye removed		30. Surgery or Hospitalization	
13. Kidney Disease, Single or Horseshoe kidney		31. Substance Abuse	
14. Concussion or Unconsciousness		32. Communicable Disease	
15. Mononucleosis		33. Fracture or Stress Fracture	
16. Allergies		34. Rupture or Hernia	
17. Blurring of Vision or other eye/vision problems		35. Dizziness or Fainting Spells	
18. Wear/ have worn Glasses or Contact lenses		36. Numbness, weakness, or tingling in arms or legs	

Name of Primary Care Physician / Family Doctor: _____

If you checked any of the above boxes, please explain fully: _____

Do you have any other information concerning your health, past or present, which is not covered by the above questions? (if yes, describe fully): _____

Are you taking any Medications or Drugs? _____ Please list and give the name of the prescribing doctor: _____

Date of Last Fight: _____ / _____ / _____
 How Many Knock Outs have you suffered? KO _____ TKO _____ Date of Last KO _____ / _____ / _____
 Longest duration of unconsciousness _____ (# of min, hour, days)
 Length of time before returning to contact _____
 Have you ever been knocked unconscious in any other sport or activity? _____
 What is your average non-fight weight? _____

Signature of Fighter: _____

To be Completed by Physician



Physical Examination for:

Height: _____ Weight: _____ Blood Pressure: _____ Temperature: _____ Pulse: _____

General appearance: _____

HEENT: _____

Pupils: Reg _____ Round _____ Equal _____ React Light Periorbital scars _____ Accom _____

Acuity _____ OD _____ OS _____

Oropharynx: _____

Neck: LA _____ Goiter _____ ROM _____

Lungs: _____

Heart: _____

Abd: _____

Inguinal region: _____

Cervical Spine/Neck: _____

Back: _____

Shoulders: _____

Arm/Elbow/Wrist: _____

Knees: _____

Ankles: _____

Hips: _____

Hands/Feet/Small Joints: Skin: _____

Neuro: _____

Gait: _____ Rhomberg: _____ FNF: _____ RAM: _____

Muscle stretch reflexes: _____ Motor: _____ Sensory: _____

Orientation: Self, time, place: _____

Mental assessment: _____

CONTESTANT IS PHYSICALLY AND MENTALLY FIT TO FIGHT IN A COMBATIVE MARTIAL ARTS COMPETITION. YES NO

Physician's Signature: _____ Date of Exam: ____/____/____

Physician's Name: _____ Practice/Company(if applicable): _____

Physician License Number: _____ State of License: _____

Street Address: _____

Phone :() _____ City: _____ State: _____ Zip: _____