



# WORLD KICKBOXING FEDERATION CANADA INC.

## Medical Examination – Amateur Contestants

Schedule 1-A

- C & B Class  A Class Ring Only  All Cage - Mixed Martial Arts
- ALL CAGE – MMA Division** - Medical examination required for all contestants wishing to participate in a combat sports event with limited equipment - Must be valid w/i 6 mos, contestant must be 18+ (**complete sections 1,2, 3, 4 & 5**)
- A Class – Ring Division** - Medical examination required for all contestants wishing to participate in a combat sports event with limited equipment - Must be valid w/i 12 mos, contestant must be 18+ (**complete sections 1, 2, 3, 4 & 5**)
- C & B Class, Cadets & Junior Divisions** - Medical examination required for all contestants wishing to participate in a combat sports event (**complete sections 1, 3 and 5**).

### 1 Identification of Applicant

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

WKF Fighter Licence No.: \_\_\_\_\_ Pseudonym: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address, street: \_\_\_\_\_ Apartment: \_\_\_\_\_

City: \_\_\_\_\_ Prov., state, country: \_\_\_\_\_ Postal code: \_\_\_\_\_

Date of birth 

year	month	day

Weight: \_\_\_\_\_ kg (lb)

### 2 Medical and Family history

Indicate any contraindications to fighting: \_\_\_\_\_

\_\_\_\_\_

### 3 Medical Examination

<b>3.1</b>	Hearing	Is there perforation of the tympanum? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> Is there hypacusis? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> Is there chronic otitis? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
<b>3.2</b>	Vision	Is there isocoria? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> Is the light reflex normal?      Left <input type="checkbox"/> Yes <input type="checkbox"/> No      Right <input type="checkbox"/> Yes <input type="checkbox"/> No Is the fundoscopic examination normal?      Left <input type="checkbox"/> Yes <input type="checkbox"/> No      Right <input type="checkbox"/> Yes <input type="checkbox"/> No Vision:      Left _____/20      Right _____/20
<b>3.3</b>	Mouth	Is there any disease of the mouth or throat? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
<b>3.4</b>	Neck (glands)	Is there any enlargement of the thyroid or lymph glands? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
<b>3.5</b>	Respiratory system	Is there any evidence of acute respiratory disease? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> Is there any evidence of chronic respiratory disease? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
<b>3.6</b>	Blood pressure	Systolic      Diastolic      At disappearance of sound 1 <sup>st</sup> reading      _____      _____      _____ 2 <sup>nd</sup> reading      _____      _____      _____
<b>3.7</b>	Heart	Pulse measured by cardiac auscultation for one minute: _____ Is there any irregularity in the heart beat? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> Is there any evidence of disease of the heart or blood vessels? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
<b>3.8</b>	Abdomen	Does examination reveal any abnormality (hepatomegaly, splenomegaly)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If so, specify: _____
<b>3.9</b>	Hernia	Is there any hernia? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
<b>3.10</b>	Nervous system	Is there any evidence of impairment of the nervous system? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>

Please complete the form and send it to: [wkfcanada@outlook.com](mailto:wkfcanada@outlook.com)

3 Medical Examination (con't)			
3.11	Hands	Is there any evidence of swelling or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.12	Alcohol	Is there any evidence of the use of alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Drugs	Is there any evidence of the use of stimulants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Tobacco	Is tobacco used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.13	General condition	Is there any evidence of a pathological conditions not specifically described and for which an additional examination would be required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.14	Thorax	Is there a fracture of the ribs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.15	Facial bones Nose & or Maxilla	Has there been a recent fracture or sprain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.16	Feet (for kick boxers)	Has there been a recent fracture or sprain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.17	Breasts (for female contestants)	Does the examination reveal any abnormality?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Is a breast prosthesis used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.18	Eyes	Examination by an ophtalmologist if the contestant is 40 years of age or older	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

4 Laboratory tests			
4.1	EEG	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal To be completed at Dr.'s discretion - <i>Attach a copy of the reports</i>	
4.2	ECG at effort	<p>If the contestant is 40 years of age or older or if he has had a physical examination which suggests cardiac problems</p> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <i>Attach a copy of the reports</i>	
4.3	Pregnancy	<p>Pregnancy blood test - A female contestant who is pregnant shall not be declared fit to fight*</p> <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
<small>* WKF Canada does not require pregnancy tests prior to each competition for amateur combat sport – All female contestants are solely responsible to report any possibility of being pregnant making them automatically un-fit</small>			
4.4	Hemogram	<input type="checkbox"/> Hepatitis B (HBs Ag) <input type="checkbox"/> Hepatitis C <input type="checkbox"/> VIH <input type="checkbox"/> Negative	<i>Attach a copy of the reports</i>

5 Others remarks (if applicable)	
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6 Examining Physician				
<p>I hereby certify that I have examined the above-named applicant and that, as a result of the examination, I consider him to be: <input type="checkbox"/> Fit to fight <input type="checkbox"/> Unfit to fight.</p>				
Physicians Name (please print): _____	Phone: _____			
And I have signed. _____ <small>signature</small>	Date <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 30px; text-align: center;">year</td> <td style="width: 30px; text-align: center;">month</td> <td style="width: 30px; text-align: center;">day</td> </tr> </table>	year	month	day
year	month	day		

Please complete the form and send it to: [wkfcanda@outlook.com](mailto:wkfcanda@outlook.com)

Additional information can be found by visiting [www.wkfcanda.com](http://www.wkfcanda.com) by email to [wkfcanda@outlook.com](mailto:wkfcanda@outlook.com) or by calling 519-222-3483