Arkansas State Athletic Commission

Arkansas Department of Health/Combative Sports
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Annual Professional Wrestling Physical Form

- Contestant must complete Contestant's portion and Doctor must complete the remainder.
- **PROVIDING FALSE INFORMATION ON THIS FORM IS SUBJECT TO FINES & OTHER LEGAL ACTION**.

TO BE COMPLETED BY CONTESTANT

1. **Name: _____ Birth Date: _____ AGE: _____ RECORD:_____ ☐ Male ☐ Female**
2. **State the date you last competed in a combative sports event: _____ Event Type/Style: _____ Result: _____**
3. **Have you ever lost consciousness (whether by knockout or other reason)? ☐ Yes ☐ No**
4. **Were you knocked out in your last bout? ☐ Yes ☐ No**
5. **Have you ever experienced a concussion of any type? ☐ Yes ☐ No**
6. **Have you experienced headaches, dizziness or loss of memory since your last bout or training for this Event? ☐ Yes ☐ No**
7. **Have you ever had any bone or joint injuries or had surgery of any kind including RK or Lasik eye surgery? ☐ Yes ☐ No**
8. **Have you ever tested positive (even if a 2nd test was negative) for HIV or Hepatitis or Staph Infection: ☐ Yes ☐ No**
9. **Are you currently being treated for any illness or taking medication (whether over the counter or prescription) ☐ Yes ☐ No**
10. **Are you allergic to any medicine or to latex? ☐ Yes ☐ No**
11. **Do you have any physical or mental condition which would cause you to not be able to participate in this Event? ☐ Yes ☐ No**
12. **Do you have a family history of any diseases or other medical conditions? ☐ Yes ☐ No**
13. **Are you pregnant or do you think you may be pregnant? ☐ Yes ☐ No**
14. **Have you ever had breast augmentation: ☐ Yes ☐ No**
15. **Please list the Name & Telephone/Cell Number for your Emergency Contact: _____**
16. **If you answered YES to any of the above questions, please list the dates, describe and provide further details for each:**

_____

I CERTIFY & AFFIRM THE FOREGOING ANSWERS ON THIS MEDICAL REPORT ARE COMPLETE AND TRUTHFUL.

Contestant's Signature: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN

Before the Event, but not more than four (4) hours prior to the start of the first bout for the Event, on which date Contestant has signed this Report, I certify that I have performed at least the following physical and/or mental observations of the above named Contestant and have reached the following conclusion(s) based on my professional medical opinion:

1. ☐ **Verified – I verbally reviewed & verified Contestant's above stated answers.**
2. **Blood pressure _____ Systolic _____ Diastolic _____ Pulse (FEMALES ONLY: Pregnancy Test ☐ Positive ☐ Negative)**
3. ☐ **Remarkable** ☐ **Unremarkable – Visual testing & observation for contagious or potentially contagious skin, eye, ear, nose or throat borne infections, contagions or other diseases including, without limitation, those associated with the scientific family staphylococcaceae or any form of conjunctivitis or trachoma**
4. ☐ **Remarkable** ☐ **Unremarkable – Visual observation of Head, Eyes, Ears, Nose & Throat with a focus on proper dilation, movement, and lack of visually identifiable infections and abnormalities**
5. ☐ **Remarkable** ☐ **Unremarkable – Audible observation of lungs and heartbeat**
6. ☐ **Remarkable** ☐ **Unremarkable – Physical examination of abdomen and orthopedic emphasizing joints**
7. ☐ **Remarkable** ☐ **Unremarkable – Cursory Neurological observation including Mental Status; Cranial Nerves; Motor Skills; Coordination & Gait; Reflexes; Sensory; and any special tests deemed prudent**
8. **COMMENTS/NOTES: If any above observation is Remarkable or abnormal, please provide explanation, details and recommendation:_____**

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BASED ON MY FOREGOING OBSERVATIONS & REVIEW OF THE CONTESTANT'S ANSWERS, I CERTIFY & ATTEST CONTESTANT IS IN SATISFACTORY CONDITION TO COMPETE IN PROFESSIONAL WRESTLING EVENTS AT THE TIME OF OBSERVATION.

Signature of Physician: _____ Medical License #_____