

SANDA ATHLETE MEDICAL HEALTH FORM 2013

ATHLETE NAME			
ADDRESS CITY POSTAL CODE Must be Resident of Alberta			
Date of Birth (yyyy-mm-dd) (Must be this age from June-October 2013)		Gender M/F	
WEIGHT (kg) (NORMAL/WALKING)		HT (cm)	
Alberta Health Care Number			

ITEM	ACCEPTABLE FOR FULL CONTACT FIGHT? Y/N	Comment
Heart Disease		
High Blood Pressure		
Lung Disease		
Renal/Hepatic/GI Disease		
Endocrine Disease		
Neurologic Disorder		
Allergies		
Medication		
Previous Surgical Procedures		
Rheumatic Fever, T.B., Pleurisy or Asthma		
Kidney or Urine Disorder, One Kidney		
Diabetes Mellitus		
Indigestion, Vomiting, Abdominal Cramps		
Acute Infections		
Fractures, Dislocations, Severe Sprains		
Epilepsy, of Applicant or in Family		
Any suspensions in combative sports? (2013)		
EEG or MRI Results Enclose Document		NOT REQUIRED FOR PROVINCIAL SELECTION
ECG Results Enclose Document		NOT REQUIRED FOR PROVINCIAL SELECTION
Blood Test Results [Hepatitis A/B/C, H.I.V.] MUST BE NEGATIVE, Enclose Document		

ATHLETE SIGNATURE	X
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(To be completed by the Physician at Consultation)

Physician's NAME	
Physician's phone number	
Physician's Signature	X

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NOTE: The following may preclude from competing: (1) Impaired Vision – Worse eye less than 20/120 and better eye less than 20/60 (2) Squint (3) Recurrent Chronic Suppurative Otitis Media (4) Chest Expansion less than 2" (5) Total Deafness (6) Albuminuria (Hernia, Organomegaly or Undescended Testis (8) Heart Lesions.

Expiration: _____ Inspiration: _____

Vision: Right Eye 20/____ Left Eye 20/____ Colour Vision: _____ Field of Vision: _____

Ears (State of T.M.S. and degree of deafness): _____

Teeth (Any braces): _____

Is there any abnormality in Chest, Heart, B.P. of C.N.S.?: _____

Is there a Hernia, Undescended Testis, Organomegaly, Cryptorchidism?:

Urinalysis (Labetix): Sugar _____ Protein _____ Blood _____

Chest X-Ray required only if there is a family history of T.B. _____

Blood Pressure B.P. _____ Pulse _____

Cardiovascular System- Normal (YES/NO) Respiratory System-Normal (YES/NO)

Abnormalities: _____

Additional for the FEMALE Athlete – NOTE: Confirmed pregnancy disqualifies from competing.

Are there Breast Lesions, Bleeding, Masses, Other Dysfunction, Pain?

Abnormality in Menstrual Pattern? Amenorrhea?

Lower Pelvic Pains?

ATHLETE IS HEALTHY AND PHYSICALLY FIT TO COMPETE IN A COMBATIVE FULL CONTACT SPORTING EVENT- YES NO

ATHLETE SIGNATURE	X
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(To be completed by the Physician at Consultation)

Physician's NAME	
Physician's phone number	
Physician's Signature of Approval	X

MAKE TWO ORIGINALS

SUBMIT ONE WITH APPLICATION

ATHLETE IS RESPONSIBLE FOR HAVING ORIGINAL FOR ANY WIEGH-INS OR EVENTS. NOT HAVING ORIGINAL DOCUMENT WILL RESULT IN DISQUALIFICATION.