

ALLSTYLES KICKBOXING ASSOCIATION OF IRELAND

MEDICAL EXAMINATION FORM

**** NO FULL CONTACT FIGHTER WILL BE ALLOWED TO COMPETE IN ANY FULL CONTACT EVENT WITHOUT HAVING THIS FORM COMPLETED AND RECEIPTED BY THE AKAI FULL CONTACT REGISTRAR****

Surname: _____ Forename: _____

Club: _____ County: _____ Date of Birth: _____

History of Family Diseases: _____

Height: _____ Weight: _____ (KG)

CVS: Pulse: _____ B.P: _____ Murmurs: _____

R.S. Chest Deformities: _____

Lungs: _____

L.S: Any Joint Deformities: _____

Any history of Fractures: _____

Abdomen: Hernia (Y/N) _____ Scars: _____

Testes: (R) _____ (L) _____

Central Nervous System: _____

Eyes: V/A (R) _____ (L) _____ Fundi: _____

Ears: _____ Hearing: _____

Urine: Glucose: _____ Protein: _____

Signed: _____ (Medical Doctor)
I confirm that the above named person is medically fit to compete in the sport of Kickboxing.

Date: _____

Form valid for twelve months:

OFFICIAL AKAI USE ONLY: DO NOT FILL OUT BELOW DOTTED LINE:

Surname: _____ Forename: _____ Club: _____ County: _____

Date of Birth: ____/____/____ Signed: _____ (AKAI Full Contact Registrar)

Doctors Stamp:
