ANABA

Australian National Amateur Boxing Association

PART ONE – Personal Details, Contest History & Medical History: *(To be completed by the APPLICANT)*

FAMILY NAME	GIVEN NAMES	
ADDRESS		POST CODE
PHONE/ MOBILE	DATE OF BIRTH (dd/mm/yyyy)	
☐ MALE ☐ FEMALE	COMBAT SPORTS REGISTRATION ☐ FIRST-TIME ☐ ANNUAL	

CONTEST RECORD	Wins	Losses	Draws
(circle) Kickboxing K1 MMA Muay thai Boxing			
Other Martial Arts: _____			

Whilst competing in a <u>combat sport contest</u> or during <u>combat sport training</u> (sparring) have you ever:

1. Had a concussion, been knocked out or lost consciousness? ☐ NO ☐ YES ➔ (List number of times): _____

Do you have or have you ever had any of the following?	Yes	No
3. Any medical problems, disability, injury or illness		
4. Respiratory problems or asthma		
5. Heart or blood pressure problems		
6. Gut or abdomen problems		
7. Urinary or pelvic problems		
8. Spine, skeletal or muscle problems		
9. Skin problems or dermatitis		
10. Diabetes		
11. Deafness, tinnitus or hearing difficulty		
12. Dentures (false teeth) or any problems wearing a mouth guard		
13. Vision problems or wear glasses/contact lens		
14. Anxiety, depression or mental illness		
Medical Questionnaire		
15. Are you currently taking any medicine, drugs or other treatment?		
16. Do you use or have you ever used steroids, testosterone or banned substances?		
17. Have you ever been admitted to hospital or had surgery?		
18. Have you had any medical tests in the past 5 years (such as x-ray, electrocardiogram or MRI)?		
19. Have you seen a doctor for any medical problem in the last 3 months?		
20. Has an accident, injury or illness kept you off work for more than one week?		
21. Have you ever had a concussion, head injury or lost consciousness (unrelated to combat sports)?		
22. Do you have any allergies or are you allergic to any medications?		
23. Have you been training for combat sports?		
24. Are you in good physical condition?		
25. Is there anything else you should declare or discuss in relation to your health or physical condition?		

If you answered (**Yes**) to any of the questions on this page, please note the question number and list the details below (include any illness, injury, disability, surgery, medications, medical condition or medical tests and relevant dates).

2. Suffered any contest/training injuries? ☐ NO ☐ YES ➔ (List injuries in coloured box below)

PART TWO – MEDICAL EXAMINATION: *(To be completed by a MEDICAL PRACTITIONER only)*

APPLICANT'S FULL LEGAL NAME:	APPLICANTS AGE

MANDATORY PHOTOGRAPHIC IDENTIFICATION CHECK OR other photo proof of identity (list):
Drivers Licence#: OR Passport#:

WEIGHT ASSESSMENT

DATE OF TODAYS EXAMINATION / /	CURRENT (TODAYS) WEIGHT (kg) [Weigh in minimal clothing & no footwear] _____kg

MEDICAL ASSESSMENT

Any identified concerns from Applicant's Part One responses, medical questionnaire answers or weight assessment? ☐ NO ☐ YES (list below)

PHYSICAL EXAMINATION/ SYSTEMIC REVIEW	Normal	Abnormal	COMMENTS
General health			
Respiratory			
Cardiovascular			
Digestive			
Urogenital/ kidneys			
Nervous system – central, peripheral			
Musculoskeletal			
Dermatology/skin			
Vision/cranial nerves			
Hearing			
Dentition			
Emotional stability, good memory of recent events/contests, able to follow conversation with attention			
Other: (list)			

THERAPEUTIC USE EXEMPTION (TUE) ASSESSMENT

Is the Applicant currently taking any medication or substances? ☐ NO (proceed to next page) ☐ YES (next question)
Is the medication/substance prohibited in sport (Refer to globaldro.com for status) ☐ NO (proceed to next page) ☐ YES (next question)

PART THREE – Certification: *(To be completed by a MEDICAL PRACTITIONER only)*

I, _____, certify that [*Name of Medical Practitioner*]

_____

[*Name of examined Applicant*]

has been assessed for medical fitness to compete in a combat sports contest and has been found:

☐ **Fit** to compete

☐ **Unfit** to compete, for the following reason _____

Signature of Medical Practitioner _____Date: ___/____/_____ Provider

Medical Practitioner's stamp:

PART FOUR – Declaration and release of information: *(To be completed by the APPLICANT)*

I declare that the information provided in this Certificate of Fitness is true and complete to the best of my knowledge and belief.

I understand it is an offence under section 53 of the *Combat Sports Act 1987* to provide false or misleading

information. I authorise (*insert name of MEDICAL PRACTITIONER*) _____to:

- obtain details of my medical records from previous medical practitioners if required; and
- provide my personal medical information to the VAMAA VABL MTV for the purposes of administering the *Combat Sports Act 1987.*

I authorise the VAMAA – VABL- MTV to release a copy of this Certificate of Fitness and my personal medical information to any other medical practitioner conducting my pre-contest medical examination for any contest I have entered.

Applicant's name (*print*)_____

Applicant's Signature_____ Date___/___/____

PARENTAL CONSENT (*this must be completed by the parent/guardian of an Applicant who is under 18 years of age*): I assert that I have the legal authority to act on behalf of the Applicant and I execute the above declaration on behalf of the Applicant.

Name of Parent/Guardian _____

Parent/Guardian Signature _____ Date___/___/____

To be completed by a MEDICAL PRACTITIONER

Applicant's Full Legal Name: _____

Identity Confirmation:

I confirm I have sighted the following photographic proof of identify for the above-named Applicant whose serology test results I have reviewed.

Driver license ☐ Passport ☐ Other(list) _____

Date of Applicant's Serology Test (must be within 12 months): **/ /**

Mandatory Screening Tests Confirmation:

I confirm that the Applicant has undertaken the following screening tests (these tests are a compulsory legal requirement under the *Combat Sports Act 1984,* do not progress clearance if you cannot confirm all three tests).

Hepatitis B Surface Antigen (HBsAG) ☐ **YES**

Hepatitis C Antibody (HCV Ab) ☐ **YES**

HIV Combined Antigen-Antibody (HIV Ag/Ab) ☐ **YES**

Serology Report:

I confirm that I have sighted and reviewed the Applicant's serology results and, if required, any other serology results and in my opinion the Applicant DOES NOT pose a risk of transmitting any of the above blood borne viruses.

☐ **YES –** Serology Clearance Granted

☐ **NO –** Serology Clearance NOT Granted

Name of Medical Practitioner: _____ **Conta**

Signature of Medical Practitioner: _____ **Date:** / /

Medical Practitioner Registration Number: _____

Medical Practitioner's stamp:.