**Part 1 -** *to be completed by* Examining Medical Practitioner

# Certificate of Fitness

### Controlled Sports Act 2019 and Regulations 2019

| **Full name of Contestant/Participant:** |
| --- |
| **Date of Birth:** |  |  |  |
| **Address:** |
| **Suburb:** | **State:** | **Post Code:** |

I certify that this person is **FIT / UNFIT** (*delete one*) to compete or participate in a controlled sport contest.

| **Medical practitioner’s signature** |
| --- |
| **Name** |  |

Medical practitioner’s stamp:

#### Serology testing

Contestants must declare to the Medical Practitioner if they have ever been diagnosed with HIV, Hepatitis B or Hepatitis C or if they have risk factors for exposure to a blood borne virus and show evidence they are managing transmission risks appropriately.

If a Medical Practitioner identifies that a contestant has one or more risk factors for exposure to HIV, Hepatitis B or Hepatitis C they should consider completing the ‘Blood Testing’ form.

The assessment of international contestants may include blood borne virus testing for applicants from high-risk countries for blood borne virus. It is at the medical practitioner’s discretion to accept international serology results. The World Health Organisation provides information on prevalence per region in the world.

It is recommended that contestants receive vaccinations for Hepatitis B, Measles, Mumps and Rubella.

**Part 2 -** Medical and Competition History

#### Section 1: Personal Details and Competition History

(To be completed by the CONTESTANT/PARTICIPANT - Please use BLOCK LETTERS)

| **Family Name** | **Given Names** |
| --- | --- |
| **Medical Examination Date** |
| **Date of Birth** |  |  |  |
| **Residential Address** |  |
| **State:** | **Post Code:** |
| **Home Phone** | **Mobile** |

##### CAREER HISTORY

1. Have you had more than three subsequent losses by Knockout or Technical Knockout (not including Tap Out or Submission in Mixed Martial Arts contests) or three subsequent combat sports contests that resulted in a concussion injury or loss of consciousness? YES [ ]  NO [ ]

Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you undertaking this certificate of fitness assessment following a medical suspension of your controlled sports registration? If so, what for?

Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you suffered any injuries while competing? YES [ ]  NO [ ]

Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had any headaches, vomiting or problems with speech or vision within 48 hours of a contest?

YES [ ]  NO [ ]

1. Have you ever been told that you have HIV, Hepatitis B or Hepatitis C?

YES [ ]  NO [ ]

1. What date did you last compete in a controlled sports (combat sports) contest?

Enter Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Section 2: Medical History

(To be completed by the MEDICAL PRACTITIONER – Patient Questionnaire)

| Yes/No | Yes/No | Yes/No |
| --- | --- | --- |
| 1. Have you at present any:
2. illness
3. disability
 |  | 1. Are you now receiving medicine, drugs, or other treatment from a medical practitioner?
 |  | 1. Has an accident or serious illness kept you off work for more than one week?
 |  |
| 1. Have you ever had any operations
 |  | 1. Have you ever been a patient in any hospital:
2. Medical
3. Other
 |  |  |
| Have you ever had or are you now suffering from any of the following? |
| 1. Rheumatic fever/ Heart disease
 |  | 1. Palpitations or pounding heart
 |  | 1. High or low blood pressure
 |  |
| 1. Swollen or painful joints (other than through injury)
 |  | 1. Shortness of breath
 |  | 1. Pneumonia/ Bronchitis or pleurisy
 |  |
| 1. Coughing blood Coughing up phlegm
 |  | 1. Tuberculosis
 |  | 1. Asthma/ Other lung disease
 |  |
| 1. Deafness/ Tinnitus
 |  | 1. Visual problems:Do you wear glasses or contact lens
 |  | 1. Fainting attacks/ Blackouts
 |  |
| 1. Fits or convulsions / Epilepsy/ Giddiness
 |  | 1. Severe headaches / Migraines
 |  | 1. Nervous trouble/ Severe depression/ Mental illness/ Attempted suicide
 |  |
| 1. Kidney disease/ Bladder disease/ Pain passing urine/ Blood in your urine
 |  | 1. Frequent indigestion
 |  | 1. Ulcer of stomach/ Ulcer of duodenum
 |  |
| 1. Gall bladder trouble/ Gall stones
 |  | 1. Diabetes
 |  | 1. Hepatitis or other jaundice/ Liver disease
 |  |
| 1. Rupture Hernia/ Swollen painful testicles
 |  | 1. Any skin trouble:Tendency to bruise or bleed easily
 |  | 1. Concussion/ Severe head injury / Loss of consciousness
 |  |
| 1. Knee injury/ Ankle injury/ Back injury/ Other joint injury or dislocation
 |  | 1. Fractured bones/ Chipped bones
 |  | 1. Paralysis (including polio)
 |  |
| 1. Any other injury, illness or disability
 |  | 1. Are you or could you be pregnant?
 |  |  |
| Have you done any of the following in the last 12 months?  |
| 1. Shared injecting needles with someone else?
 |  | 1. Gotten a needlestick injury?
 |  | 1. Had blood or mucous from another person come into contact with an open wound, your mouth or eyes?
 |  |
| 1. Had sex without a condom with a new partner?
 |  | 1. Gotten a tattoo or skin piercing?
 |  | 1. Travelled to another country?
 |  |
| 1. Been incarcerated (in prison)?
 |  | 1. Had a blood transfusion, organ or tissue transplant?
 |  | 1. Contracted a Sexually Transmitted Infection (STI)?
 |  |

##### Medical Practitioner’s Notes on History

(A ‘Yes” answer to any question requires the medical practitioner to state question number and comment/s here)

1. Over the past five (5) years has the Contestant/Participant, either occasionally or regularly,
taken any stimulants, sedatives, medications or drugs by mouth or by injection? YES [ ]  NO [ ]

*If ‘Yes”, provide details and, if prescribed by a doctor, include the relevant particulars in question 36 below.*

Photographic identification provided to the medical practitioner: Driver licence [ ]  Passport [ ]

| *Identification number:* |  |
| --- | --- |

**Part 3 -** Record of Medical Examination prior to Registration/Renewal of Registration

(To be completed by the MEDICAL PRACTITIONER – physical examination)

| Normal/Abnormal | Normal/Abnormal | Normal/Abnormal |
| --- | --- | --- |
| 1. a - Head, face, scalp

b - Neck R.O.M. |  | 1. a - Nose deformity

b - Nose airway |  | 1. a - Mouth, throat

b - Speech |  |
| 1. a - Teeth, gums

b - Dentures Yes / No |  | 1. a - Ears – general

b - Ears – hearing |  | 1. Tympanic membranes
 |  |
| 1. Eustachian tubes
 |  | 1. Eyes – general
 |  | 1. a - Visual fields

b - Eye gaze |  |
| 1. Eye movement
 |  | 1. Ophthalmoscopic examination
 |  | 1. Chest, lungs
 |  |
| 1. Heart (if ECH performed, note result in section & enclose F MED 53)
 |  | 1. Vascular system (include veins)
 |  | 1. Abdomen (include hernia orifices)
 |  |
| 1. Endocrine system
 |  | 1. External genitalia
 |  | 1. a - Feet

b - Limbs R.O.M c – Gait |  |
| 1. a - Spine

b - Trunk R.O.M.c - Posture (standing) |  | 1. a - Nervous system

b - Cranial nerves |  | 1. a - Cerebellum function

b - Body balance/ coordination |  |
| 1. a - Muscle tone

b - Muscle strengthc - Sensation |  | 1. Reflexes
 |  | 1. Skin
 |  |
| 1. Lymphatic system

Lymph glands in neckaxillae or inguinal |  | 1. Emotional stability
 |  | 1. Other
 |  |
| 1. Identifying marks
 |  | 1. *Frame* -

SmallMediumLarge |  | 1. *Height:*

\_ \_ \_ \_ \_ \_ \_ (cm) |
| 1. *Chest:*

\_ \_ \_ \_ \_ \_ \_ (cm) Exp \_ \_ \_ \_ \_ \_ \_Ins \_ \_ \_ \_ \_ \_ \_ | 1. Waist:

\_ \_ \_ \_ \_ \_ \_ (cm) |  | 1. *Urinalysis:*

Albumin \_ \_ \_ \_ \_ \_ \_Sugar \_ \_ \_ \_ \_ \_ \_ |
| 1. Weight:

\_ \_ \_ \_ \_ \_ \_ (kg) | 1. *Blood Pressure:*

Systolic \_ \_ \_ \_ \_ \_ \_Diastolic \_ \_ \_ \_ \_ \_ \_ |  |  |
| 1. *Distant vision:*

R6 \_ \_ \_ \_ \_ \_ \_L6 \_ \_ \_ \_ \_ \_ \_Corr 6 \_ \_ \_ \_ \_ \_ \_to 6 \_ \_ \_ \_ \_ \_ \_*Near vision*:  Normal  Abnormal | 1. Has a MRI Scan been conducted?

**** Yes **** NoIs the MRI satisfactory?**** Yes **** NoAny further testing required? **** Yes **** No |

##### Medical Practitioner’s Notes on Medical Examination

(Provide details of any abnormality noted and enter the relevant question number before each comment)

1. Is any further testing required? YES [ ]  NO [ ]

Details :

**Neuro/Psychological Examination**

1. Is there any evidence of a change in character? YES [ ]  NO [ ]
2. Has the contestant a good memory for recent events and, in particular, recent contests? YES [ ]  NO [ ]
3. Does the contestant follow conversation with attention and intelligence? YES [ ]  NO [ ]
4. Is any further testing required? YES [ ]  NO [ ]
5. Is there any evidence of a tendency to violence outside the competitive arena? YES [ ]  NO [ ]

##### Medical Practitioner’s Notes on Neuro/Psychological Examination

(State whether further assessment is required)

1. Particulars of any Disabilities

| Contestant/Participant’s Declaration and Release of Medical Information Authorisation |
| --- |
| I declare that the information provided in this ‘Certificate of Fitness’ is true and complete to the best of my knowledge and belief. I declare that I am not knowingly competing with an unmanaged blood borne virus (HIV, Hepatitis B or Hepatitis C).I authorise *(insert name of MEDICAL PRACTITIONER)* \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ to provide personal medical information to the ACT Registrar for Controlled Sports for administering the *Controlled Sports Act 2019* and authorise the medical practitioner to obtain details of my medical records from previous medical practitioners if required.Contestant/Participant name *(print)* \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Signed\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Date \_\_/ \_\_/ \_\_I have completed the above Medical History and have witnessed the contestant/participant signature.Medical Practitioner name *(print)* \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Signed\_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ Date \_\_/ \_\_/ \_\_ |

#### Medical Practitioner’s Summary

| Name of examined contestant |  |
| --- | --- |
| Do you consider the contestant to be fit to participate as a Contestant in combat sports contests? YES [ ]  NO [ ]  Further Assessment Required[ ]  |
| Any comments |  |
|  |
|  |
| Signature of medical practitioner |  |
| Name of medical practitioner *(please print)* |  |
| Date |  |