

Part 1 - to be completed by Examining Medical Practitioner

Certificate of Fitness

Controlled Sports Act 2019 and Regulations 2019

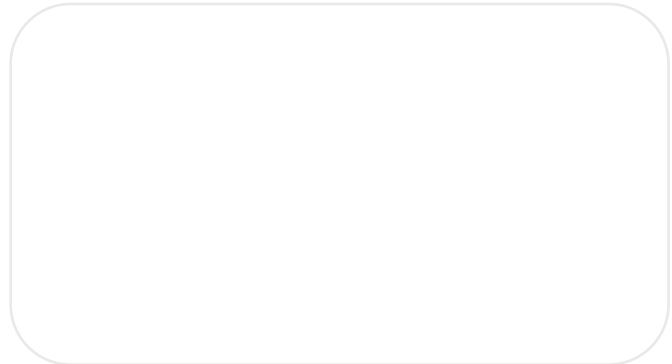
Full name of Contestant/Participant:		
Date of Birth:		
Address:		
Suburb:	State:	Post Code:

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

- 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 _____
- Are you undertaking this certificate of fitness assessment following a medical suspension of your controlled sports registration? If so, what for?
Please specify _____
- Have you suffered any injuries while competing? YES NO
Please specify _____
- Have you had any headaches, vomiting or problems with speech or vision within 48 hours of a contest?
YES NO
- Have you ever been told that you have HIV, Hepatitis B or Hepatitis C?
YES NO
- 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: a) illness b) disability		2. Are you now receiving medicine, drugs, or other treatment from a medical practitioner?		3. Has an accident or serious illness kept you off work for more than one week?	

4. Have you ever had any operations		5. Have you ever been a patient in any hospital: a) Medical b) Other	
Have you ever had or are you now suffering from any of the following?			
6. Rheumatic fever/ Heart disease		7. Palpitations or pounding heart	8. High or low blood pressure
9. Swollen or painful joints (other than through injury)		10. Shortness of breath	11. Pneumonia/ Bronchitis or pleurisy
12. Coughing blood Coughing up phlegm		13. Tuberculosis	14. Asthma/ Other lung disease
15. Deafness/ Tinnitus		16. Visual problems: Do you wear glasses or contact lens	17. Fainting attacks/ Blackouts
18. Fits or convulsions / Epilepsy/ Giddiness		19. Severe headaches / Migraines	20. Nervous trouble/ Severe depression/ Mental illness/ Attempted suicide
21. Kidney disease/ Bladder disease/ Pain passing urine/ Blood in your urine		22. Frequent indigestion	23. Ulcer of stomach/ Ulcer of duodenum
24. Gall bladder trouble/ Gall stones		25. Diabetes	26. Hepatitis or other jaundice/ Liver disease
27. Rupture Hernia/ Swollen painful testicles		28. Any skin trouble: Tendency to bruise or bleed easily	29. Concussion/ Severe head injury / Loss of consciousness
30. Knee injury/ Ankle injury/ Back injury/ Other joint injury or dislocation		31. Fractured bones/ Chipped bones	32. Paralysis (including polio)
33. Any other injury, illness or disability		34. Are you or could you be pregnant?	
Have you done any of the following in the last 12 months?			
35. Shared injecting needles with someone else?		36. Gotten a needlestick injury?	37. Had blood or mucous from another person come into contact with an open wound, your mouth or eyes?
38. Had sex without a condom with a new partner?		39. Gotten a tattoo or skin piercing?	40. Travelled to another country?
41. Been incarcerated (in prison)?		42. Had a blood transfusion, organ or tissue transplant?	43. 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)

35. 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	Normal/Abnormal
1. a - Head, face, scalp b - Neck R.O.M.	2. a - Nose deformity b - Nose airway	3. a - Mouth, throat b - Speech	
4. a - Teeth, gums b - Dentures Yes / No	5. a - Ears – general b - Ears – hearing	6. Tympanic membranes	
7. Eustachian tubes	8. Eyes – general	9. a - Visual fields b - Eye gaze	
10. Eye movement	11. Ophthalmoscopic examination	12. Chest, lungs	
13. Heart (if ECH performed, note result in section & enclose F MED 53)	14. Vascular system (include veins)	15. Abdomen (include hernia orifices)	
16. Endocrine system	17. External genitalia	18. a - Feet b - Limbs R.O.M c – Gait	
19. a - Spine b - Trunk R.O.M. c - Posture (standing)	20. a - Nervous system b - Cranial nerves	21. a - Cerebellum function b - Body balance/ coordination	
22. a - Muscle tone b - Muscle strength c - Sensation	23. Reflexes	24. Skin	

Normal/Abnormal		Normal/Abnormal		Normal/Abnormal	
25. Lymphatic system Lymph glands in neck axillae or inguinal		26. Emotional stability		27. Other	
28. Identifying marks		29. <i>Frame</i> - Small Medium Large		30. <i>Height</i> : _____ (cm)	
31. <i>Chest</i> : _____ (cm) Exp _____ Ins _____		32. <i>Waist</i> : _____ (cm)		33. <i>Urinalysis</i> : Albumin _____ Sugar _____	
34. <i>Weight</i> : _____ (kg)		35. <i>Blood Pressure</i> : Systolic _____ Diastolic _____			
36. <i>Distant vision</i> : R6 _____ L6 _____ Corr 6 _____ to 6 _____ <i>Near vision</i> : <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				37. Has a MRI Scan been conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the MRI satisfactory? <input type="checkbox"/> Yes <input type="checkbox"/> No Any further testing required? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Medical Practitioner’s Notes on Medical Examination

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

39. Is any further testing required? YES NO
Details :

Neuro/Psychological Examination

40. Is there any evidence of a change in character? YES NO
41. Has the contestant a good memory for recent events and, in particular, recent contests? YES NO
42. Does the contestant follow conversation with attention and intelligence? YES NO
43. Is any further testing required? YES NO
44. 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)

45. 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 _____