



FLORIDA ATHLETIC COMMISSION
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DILATED OPHTHALMOLOGICAL EXAMINATION
(To be performed ONLY by an OPHTHALMOLOGIST or OPTOMETRIST)

To be completed by Participant (Fighter)

NAME: _____
(LAST) (FIRST) (MIDDLE)

AGE: _____ BIRTH DATE: ___/___/___ SS#: _____

HAVE YOU EVER HAD ANY EYE DISEASES? YES NO
List the nature of diseases: _____

HAVE YOU EVER SUFFERED ANY EYE INJURY? YES NO
List the nature of this injury: _____

HAVE EITHER OF YOUR EYES EVER BEEN OPERATED ON FOR
DETACHED RETINA OR FOR ANY OTHER REASON? YES NO

EXAMINATION - To be completed by examining Ophthalmologist or Optometrist

Date of Examination: _____

VISION:
NAKED EYE: _____ (LEFT) WITH CORRECTIVE LENSES: _____ (LEFT)
_____ (RIGHT) _____ (RIGHT)

REMARKS:
ANY EVIDENCE OF PRESENT OR FORMER DISEASE? GIVE SPECIFICS _____

LEFT/ RIGHT	REMARKS
LIDS? : _____/_____	_____
CONJUNCTIVA?: _____/_____	_____
GLAUCOMA? : _____/_____	_____
CORNEA? : _____/_____	_____
PANNUS? : _____/_____	_____
IRIS? : _____/_____	_____
CHOROID? : _____/_____	_____
PTOSIS? : _____/_____	_____
RETINA? : _____/_____	_____
IF TRACHOMA IS PRESENT, IS IT ACTIVE? : _____ (L)/ _____ (R)	_____
WHEN WAS IT LAST TREATED? : _____	_____
DISCHARGE? : _____/_____	_____
FOLLICIES? : _____/_____	_____
CATARACT? : _____/_____	_____
CORNEAL LEUCOMA? _____/_____	_____

- I HEREBY CERTIFY THAT BASED ON THE STATEMENTS MADE BY THE PARTICIPANT AND/OR MY PHYSICAL FINDINGS, IT IS MY OPINION THAT SAID PARTICIPANT HAS A NORMAL EYE EXAMINATION AND IS ABLE TO ENGAGE IN BOXING, KICKBOXING, OR MIXED MARTIAL ARTS MATCHES.
- I HEREBY CERTIFY THAT BASED ON THE STATEMENTS MADE BY THE PARTICIPANT AND/OR MY PHYSICAL FINDINGS, IT IS MY OPINION THAT SAID PARTICIPANT DOES NOT HAVE AN APPROPRIATE EYE CONDITION TO ENGAGE IN BOXING, KICKBOXING, OR MIXED MARTIAL ARTS MATCHES.

SIGNATURE OF OPHTHALMOLOGIST/OPTOMETRIST

(PLEASE PRINT) NAME OF
OPHTHALMOLOGIST/OPTOMETRIST

LICENSE NUMBER OF OPHTHALMOLOGIST/OPTOMETRIST

OFFICE PHONE NUMBER OF
OPHTHALMOLOGIST/OPTOMETRIST