MEDICAL INFORMATION SHEET
TO BE COMPLETED BY FIGHTERS

NAME: _____

BIRTH DATE:_____

ANY SERIOUS MEDICAL CONDITIONS: **YES OR NO**

ANY SURGERIES: **YES OR NO**

ANY DRUG ALLERGIES: **YES OR NO**

FIGHTERS SIGNATURE: _____ **DATE:** _____

DO NOT WRITE BELOW THIS LINE

TO BE COMPLETED BY PHYSICIAN ONLY

PRE PHYSICAL

EYES: _____ **HEAD:** _____ **HEART:** _____

LUNGS: _____ **EXTREMITIES:** _____

BP: _____ **PULSE:** _____ **SKIN:** _____
(ANY OPEN WOUNDS)

LABS

HIV _____ **HEP B SURFAC ANTIGEN** _____ **HEP C ANITBODY** _____

CLEARED TO FIGHT: _____

PHYSICIAN: _____ **DATE:**_____

OFFICE PHONE: _____

SPECIAL NOTES:

_____
_____
_____
_____
_____