CALIFORNIA AMATEUR MIXED MARTIAL ARTS ORGANIZATION, INC.
INTERNET: www.camo-mma.org
E-MAIL: info@camomma.org
PH: (213) 908-2185; FAX: (888) 663-9915

AMATEUR ATHLETE PHYSICAL EXAMINATION

APPLICANT NAME   RING NAME   TELEPHONE   DATE OF BIRTH

ADDRESS   CITY   STATE   ZIP CODE   COUNTRY

PHYSICAL HISTORY: Have you ever had any of the following conditions?:

☐ None

☐ Fainting spells	☐ Rupture (hernia)	☐ Chest pains
☐ Operations	☐ Shortness of breath	☐ Swollen joints
☐ Rheumatism	☐ Diabetes	☐ Frequent headaches
☐ Convulsions (fits)	☐ Chronic cough	☐ Spitting of blood

☐ Cerebral hemorrhage or serious head injury

Please Explain:____

Number of knockout losses in your career: __________ Date of last knockout: _____________

Have you ever suffered a loss of consciousness for any reason?: ☐ NO ☐ YES

If YES, please explain and provide date(s) and location(s):

When was the last time you took any type of medication or drug? (State what type and when)

Have you ever undergone any type of surgery? ☐ **No** ☐ **Yes** If YES, please describe (State what type and when):

When was the last time you took any type of vitamin supplement? (State what type and when)

Amateur record: Wins ________ Losses ________ Draws ________

Professional boxing/kickboxing: Wins ________ Losses ________ Draws ________

Additional information: ____

PHYSICAL EXAMINATION (ALL FIELDS REQUIRED):

General appearance: ______________________ Height: ________ Weight: _________ Temperature: ________

Disabling scars: ____________ Mouth: ___________ Teeth: _____________ Tonsils: ________ Neck: ________

Pulse at rest: _________ Pulse after 100 hops: ____________

Blood pressure: At rest: ___________ After 100 hops: ___________ 2 minutes later: __________

Heart Pulse Rhythm:	☐ Regular	☐ Irregular	Lungs: Rales	☐ No	☐ Yes
Murmurs:	☐ No	☐ Yes	Goiter:	☐ No	☐ Yes
Apical impulse:	☐ Normal	☐ Heavy	Enlarged glands:	☐ No	☐ Yes
Enlargement:	☐ No	☐ Yes	Testicles: Normal	☐ Yes	☐ No
Breasts: Tenderness	☐ No	☐ Yes	Hernia:	☐ No	☐ Yes
Breasts: Mass	☐ No	☐ Yes	Abdomen: Enlargement of liver	☐ No	☐ Yes
Breasts: Discharge	☐ No	☐ Yes	Enlargement of Spleen:	☐ No	☐ Yes

Remarks:____

Reflexes: Pupils __________ Knee jerks ____________ Romberg ___________

Babinski ___________ Skin: Tone ____________ Rash _________Boils ____________Other:_______________

Unhealed wounds:____

Remarks:____

EYE HISTORY: Have you ever had any of the following conditions:
Blurred vision? □ **No** □ **Yes** – If YES, please explain in full:

____

____

Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye? □ **No** □ **Yes** – If YES, please explain in full:

____

____

Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? □ **No** □ **Yes** – If YES, please explain in full:

____

____

EXAMINING PHYSICIAN:
I have examined the above named applicant and **I DO NOT FIND** a condition that would preclude him/her from being licensed as amateur mixed martial arts athlete.

Authorization for release of medical information is attached.

______________________________________	___________________________________		
***LICENSED PHYSICIAN'S NAME (print)**	***MEDICAL LICENSE NUMBER**		
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
TELEPHONE NUMBER	**APPOINTMENT DATE/TIME**		

____
PHYSICIAN'S SIGNATURE (MD or DO ONLY*)

*Must be a licensed physician **(MD or DO ONLY)**. No physician assistant (PA) or nurse (NP) signatures accepted without accompanying physician name, signature, and medical license number.

Please note: Athletes who are **40 years of age or older must also complete the separate CAMO Cardiovascular History Form and undergo an EKG test providing CAMO with results and doctor's signoff showing proper fitness for competition.

Submission Instructions:
Submit completed medicals to **1-888-663-9915** or e-mail to **info@camomma.org** for processing. Ensure **ALL** fields are completed with the physician in full prior to submission or the submission will be denied.