MUAYTHAI ONTARIO ANNUAL MEDICAL FORM

ATHLETE MEDICAL DECLARATION

TO BE COMPLETED BY THE ATHLETE OR GUARDIAN

First Name:		Last Name:	
Date of Birth (DD/MM/YYYY):	Age:	Gender:	Nationality:

DO YOU HAVE ANY OF THESE MEDICAL CONDITIONS?								
CONDITION:	YES	NO	CONDITION:	YES	NO	CONDITION:	YES	NO
Bleeding or other blood disorder			Epilepsy/seizure			Cataracts		
Open wound/sutured cut			Blurred vision			Diabetes		
High temperature/pyrexia			Hearing loss			Fainting		
Headaches/migraines			Balance problems			Dizziness		
Abnormal blood pressure			Asthma/bronchitis			Hernia		
Any heart condition			Recurrent neck pain			HIV		
Chest trauma/rib fracture			Recurrent back pain			Hepatitis		
Chronic or acute infectious disease			Mental illness			Pregnancy		
Organomegaly, cryptorchidism			Kidney or urine disorder			Breast lesions		

IN THE LAST 6 MONTHS HAVE YOU HAD	YES	NO	IF YES, DETAILS
A contest that ended in a KO or head injury			
Any type of surgery			
Inpatient hospital treatment			
Treatment for a fracture / fissure / dislocation			

HAVE YOU EVER HAD	YES	NO	IF YES, DETAILS
Back or spinal surgery?			
A positive test with an anti-doping agency?			
A blood clot in your legs / lungs / heart / brain / other major organs?			
A retinal detachment?			
A concussion or traumatic brain injury?			
Any hormone/endocrine disorders?			

PLEASE LIST	DETAILS
Any allergies	
All medications you are currently taking A Theraputic Use Exemption is required for WADA prohibited substances	
Any other conditions not listed	

MEDICAL HISTORY STATEMENT

I understand it is my responsibility to be familiar with the World Anti-Doping Agency prohibited list, and, in the event I am taking medication that contains a prohibited substance acquire the appropriate therapeutic use exemption.

I have completed this medical history questionnaire and answered it truthfully and to the best of my knowledge. I am prepared to answer questions from Muaythai Ontario, or the International Federation of Muaythai Amateur (including athletic trainers, nurses, consultants, coaches, and coordinators) and general practitioners concerning this medical history and medical conditions. I affirm also that I do not suffer from any disability, injury, condition, or complaint that I have not disclosed on this form. I further recognize the importance of fully and accurately disclosing my physical conditions, past and present. In the event that any information submitted on this declaration changes or no longer holds true I will update Muaythai Ontario, or the International Federation of Muaythai Amateur of the changes prior to my continued competition under their jurisdiction.

Athlete Name	Athlete Signature	Guardian Signature (If Under 18)	Date (DD/MM/YYYY)

This declaration must be dated within 12 months prior to provincial, national or international competition

Please bring completed medicals and blood test results on the day of your event

MUAYTHAI ONTARIO ANNUAL MEDICAL FORM

MEDICAL EXAMINATION

TO BE COMPLETED BY THE MEDICAL DOCTOR

Please note that the following may preclude from competition at Muaythai Ontario's (1) Impaired Vision – worse eye less than 20/200 and better eye less than 20/120 (2) Squint (3) Recurrent Chronic Suppurative Otitis Media (4) Chest Expansion Less than 2" (5) Total Deafness (6) Albuminuria (7) Hernia, Organomegaly or Undescended Testis (8) Heart Lesions.

ATHLETE INFORMATION			
Weight: (kg)	Height: (cm)	Expiration:	Inspiration:
Left Eye Vision: (Unadjusted)	Right Eye Vision: (Unadjusted)	Colour Vision:	Field of Vision:
Pulse:	Blood Pressure:		

GENERAL HEALTH	YES	NO	IF YES, EXPLAIN
Vision: Abnormality of pupils?			
Mouth: Any disease of mouth or throat?			
Hands: Evidence of swelling or injury?			
Abdomen: Any abnormality?			
Evidence of stimulant/substance abuse?			

I _____ *certify that* _____

(Licensed Medical Physician's Name) *(Athlete's name)*

Is Fit ☐ *Is Not Fit* ☐

To participate in competitions of the full contact sport of Muaythai.

Physician Signature:	License #:	Date (DD/MM/YYYY):	Stamp:
Physician Address:	Telephone:	Email:	Medical form will not be accepted without a Physician's stamp.

LABORATORY TESTING FOR ATHLETES AGE 16+

Laboratory testing is mandatory for all athletes age 16 and above, and must be attached to this medical declaration. Test results must be dated in the 12 months prior to national competition and 6 months prior to international competition.

TEST	DATE OF TEST (DD/MM/YYYY)	PAPERWORK ATTACHED	PHYSICIAN INTERPRETATION
HIV Antibody (HIVAb)			
Hepatitis B Surface Antigen (HBsAg)			
Hepatitis C Antibody (HCVAb)			

Please bring completed medicals and blood test results on the day of your event

IMPORTANT

PLEASE ENSURE THAT YOUR PHYSICIAN ORDERS THE CORRECT HEPATITIS B TEST

HEPATITIS B SURFACE ANTIGEN (HBsAg)

PHYSICIANS FREQUENTLY ORDER THE WRONG HEPATITIS B TEST. NO OTHER HEPATITIS B SCREENING WILL BE ACCEPTED.

SAVE PAPER, DON'T PRINT THIS PAGE.