TEXAS DEPARTMENT OF LICENSING & REGULATION
P.O. Box 12157 • Austin, Texas 78711-2157
(512) 539-5722 • FAX (512) 463-1087
www.tdlr.texas.gov • combative.sports@tdlr.texas.gov

AMATEUR COMBATIVE SPORTS CONTESTANT REGISTRATION
(Including Physical Exam & Eye Exam)

Submit all medical exams and test results with this registration form.

Full Legal Name:	
First, Middle, Last	
Gender: Male Female	
Mailing Address:	
Street Number, Street Name, Apt. or Ste. #, City, State, Zip	
Telephone #:	Date of Birth:
Social Security #	Place of Birth:
(Foreign Nationals may submit Passport #)	(City & State or Country is not U.S. Citizen)
Email Address:	
Association Name:	Event Date:

Amateur Affidavit

I certify, under penalty of perjury, that I have not participated in any Combative Sports Event for profit or as a professional.

By signing this registration form, I certify that all information is true and correct. I understand that providing false information on this form may result in sanctions up to and including denial or revocation of the registration.

______________________________ ____________________
Contestant Signature Date

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please read this entire form before signing and complete all sections.

1. I authorize the Texas Department of Licensing and Regulation to use and disclose my protected health information medical records to the appropriate governmental authorities or myself with respect to my status as a licensed contestant.

2. This authorization for release of information covers all past, present, and future medical records.

3. I authorize the release of all protected health information medical records submitted to TDLR as a part of the following

   - Amateur Contestant's Medical Examination - Part 1
   - Amateur Contestant's Medical Examination - Part 2
   - Ophthalmologic Medical Exam

4. I understand that the authorization to release **all** of the above-referenced protected health information records **includes** the release of information records relating to communicable diseases, *Human Immunodeficiency Virus* **HIV** or Acquired Immune Deficiency Syndrome **AIDS**.

5. This authorization shall remain in effect until the expiration of my license, at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I have read this form and agree to the uses and disclosure of the health information medical records as described.

I understand that refusing to sign this form does not affect disclosures of health information medical records that have occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy law.

____
PRINT NAME OF APPLICANT

____ ____________________
SIGNATURE OF APPLICANT DATE SIGNED

Contestant Name (Please Print): ____

AMATEUR CONTESTANT'S MEDICAL EXAMINATION – PART 1

TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR ONLY
Forms completed by a physician assistant or nurse practitioner will NOT be accepted.

Medical Allergies:

Medications? YES NO Explain:

Previous Hospitalization(s) or Surgery (include dates):

The following blood tests must be attached to this application: Hepatitis B surface ANTIGEN Hepatitis C ANTIBODY HIV ANTIBODY	**Contestants 36 and over must also provide a favorable:** EEG (Electroencephalography) and EKG (Electrocardiogram)

ALL MEDICAL AND LAB TEST RESULTS MUST BE DATED, SIGNED AND TAKEN NO MORE THAN 6 MONTHS BEFORE THE REGISTRATION IS SUBMITTED.

Health History:

Do you have or have you ever had any of the following?

	YES	NO		YES	NO
Bleeding Tendencies			Seizures and Convulsions		
Diabetes			Asthma		
Hernia			High Blood Pressure		
Heart Disease			Tuberculosis		
Sickle Cell Disease			Mononucleosis		
Kidney Disease			Cough		
Hepatitis			Psychiatric Problems		
Skin Disease			Contact Lenses		
Headaches			Number of Times KO'D		
Joint Injury or Dislocation			Kidney/Lung/Testicle/Eye Removed (circle all that apply)		
Concussion/Unconsciousness					

If 'YES' to any of the above, explain: ____

____

Do you have any other information concerning the contestant's health, past or present, which is NOT COVERED by the questions above? If so, describe: ______________________________

EXAMINING MD or DO NAME (Please print) ______________________________

MEDICAL LICENSE # ______________________________ **Phone** ______________
(Must be licensed in a State, District or Territory of the United States)

ADDRESS ____
(Street Number, Street Name, Suite Number, City State, Zip Code)

MD or DO SIGNATURE ______________________________ **DATE** ______________

CONTESTANT SIGNATURE ______________________________ **DATE** ______________

Contestant Name (Please Print): ____

AMATEUR CONTESTANT'S MEDICAL EXAMINATION – PART 2

This section must be completed by the examining physician.

		Normal	Abnormal
Ears	Auditory Canals		
	Drums		
	Auditory Acuity		
Nose			
	General		
	Fractures		
Oropharynx			
	Tonsils		
	Gums		
	Teeth		
	Tongue		
	Neck		
Skin			
	Infection		
	Cyanosis		
	Hair Distribution		
Lymphatic System			
Musculoskeletal/Spinal			
	Curvature		
	Posture		
	Tenderness		
	Range of Motion		

		Normal	Abnormal
Abdomen			
	Scars		
	Liver		
	Kidneys		
	Spleen		
	Inguinal Area		
Extremities			
	General		
	Joint Mobility		
Neurological			
	Gait		
	Finger to Nose		
	Knee Jerks		
	Bicep Jerks		
	Rhomberg		
	Babinski		
	Brudzinski		
	Cranial Nerves		
	Other		
Thorax			
	Lungs		
	Heart (size, murmur)		

Heart Rate ________ Blood Pressure (S) _______ (D) _______

Pulse Rate ________ Immediately after 20 Hops ________ 2 Minutes after Exercise _________

Abnormalities: ____

Other: ____

I hereby certify that I examined ______________________________ on ____________.
contestant's name **date**

I HAVE APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT.

MD/DO SIGNATURE ______________________________ DATE______________

CONTESTANT SIGNATURE ______________________________ DATE ______________

Contestant Name (Please Print): ____

** OPHTHALMOLOGIC MEDICAL EXAM **			
Exam with dilation must be done by an Ophthalmologist or Optometrist.			
Examination (Normal = N; Abnormal = X)	Right Eye	Left Eye	Normal Abnormal
Visual Acuity (without correction)	F /	F /	
	N /	N /	
Visual Acuity (with correction)	F /	F /	
	N /	N /	
Exterior Exam			
Anterior Exam			
Fundi			
Extraocular Muscles			
Visual Fields			
Tonometry			
Explain abnormal findings:			
Diagnosis:			

I hereby certify that I examined ______________________________ **on** ____________________.
(Please print contestant's name) **(date)**

I HAVE APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT.

Name of Ophthalmologist or Optometrist ____
(Please print)

LICENSE # ______________________________ **Phone** ____________________
(Must be licensed in a State, District or Territory of the United States)

ADDRESS ____
(street number, street name, suite number, city, state, zip code)

OPHTHAMOLOGIST or
OPTOMETRIST SIGNATURE ______________________________ **DATE** ____________________

CONTESTANT SIGNATURE ______________________________ **DATE** ____________________