

Iowa Fighter Pre-Bout Physical Form

**Iowa Division of Labor
Athletic Commission**
1000 East Grand Avenue
Des Moines, IA 50319-0209
Phone: 515-281-8067
Fax: 515-281-5361
iowadivisionoflabor.gov/athletic
pamela.conner@iwd.iowa.gov

Event Date: _____
Promoter: _____
Event Location: _____
Event City: _____
Record: Win _____ Loss _____ D _____
Opponent: _____

Form must be filled out prior to physical exam

Fighter Information

Legal Name		Date of Birth	Fight Name	
Address		City	State	Zip
Phone Number	Emergency Contact		Phone Number	
Have you ever been advised not to fight by a healthcare professional? If yes, explain:			Yes	No
Do you have any medical conditions (diabetes, asthma, heart condition, etc.)? If yes, explain:			Yes	No
Have you had any previous surgeries? If yes, explain:		Yes	No	
Have you ever been hospitalized? If yes, explain:		Yes	No	
Do you wear contact lenses? Yes No		Have you had a recent fracture or dislocation? Yes No If yes, date:		
Have you been knocked unconscious? Yes No If yes, date:			Have you ever had a head injury or concussion? Yes No If yes, date:	
Fighter's Signature			Date	

To be Completed by Physician Before Fight

Height	Weight	Blood Pressure	Pulse
Overall Appearance Normal Abnormal	Eyes Normal Abnormal	Ears Normal Abnormal	Nose Normal Abnormal
Skin Normal Abnormal	Upper Extremities Normal Abnormal	Abdomen Normal Abnormal	Cervical Exam Normal Abnormal
Lungs Clear Restricted	Heart Normal Abnormal	Heal Walk Normal Abnormal	Toe Walk Normal Abnormal
Coordination Exam Normal Abnormal	Any reason to bar this contestant from this match? If yes, explain: _____		Yes No

I find this fighter to be in good physical condition and able to compete on _____ .
(date of event)

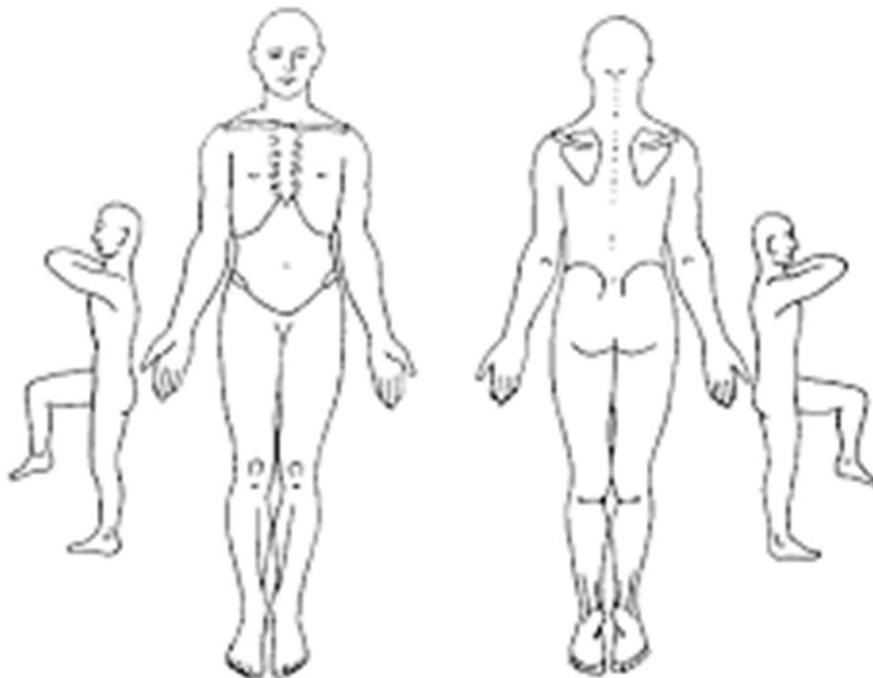
Physician's Printed Name Physician's Signature Date

To be Completed by Physician After Fight

Obvious injuries or complaints: _____

Win

Loss



Loss of Consciousness?	Yes	No	Eyes Normal?	Yes	No
Gait Steady?	Yes	No	Oriented?	Yes	No
Alert?	Yes	No	N1 Speech?	Yes	No
Return to N1 after _____	Minutes	_____	Seconds		
Fractures?	Yes	No	If yes, explain: _____		

Procedures performed by ringside medical personnel: _____

Post Fight Medical Suspensions or Recommendations

Suspension: None 7 days (minimum) - Date lifted: _____ 14 days - Date lifted: _____

30 days - Date lifted: _____ Other: _____

Mandatory referral: None Emergency room Other: _____

Medical release required to fight again: Yes No

Medical personnel printed name Signature Date Time

Fighter's Signature: _____