



## Professional Combatant Dilated Eye Exam

Only a licensed Ophthalmologist or Optometrist may conduct this examination and complete this form. Please complete this form in its entirety.

Full Name: \_\_\_\_\_

First Name

Middle Name

Last Name

### HISTORY

Has applicant ever had any of the following conditions?

- 1. Blurred vision? [ ] Yes [ ] No
- 2. Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye? [ ] Yes [ ] No
- 3. Has applicant had or been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or cataract? [ ] Yes [ ] No

If yes, please explain: \_\_\_\_\_

- 4. Eye Disease? [ ] Yes [ ] No

If yes, list nature of diseases: \_\_\_\_\_

- 5. Eye Injury? [ ] Yes [ ] No

If yes, list nature of injuries: \_\_\_\_\_

- 6. Retinal reattachment? [ ] Yes [ ] No

If yes, please explain: \_\_\_\_\_

- 7. Does the applicant have any other visual condition that would prevent him/her from safely engaging in boxing or martial arts activities? [ ] Yes [ ] No

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### EXAMINATION

Vision: \_\_\_\_\_  
Without glasses                      With Glasses

Refraction: If either eye is 20/60 or worse

Right \_\_\_\_\_ / \_\_\_\_\_ Right \_\_\_\_\_ Sph \_\_\_\_\_ Cyl x \_\_\_\_\_ Acuity \_\_\_\_\_

Left \_\_\_\_\_ / \_\_\_\_\_ Left \_\_\_\_\_ Sph \_\_\_\_\_ Cyl x \_\_\_\_\_ Acuity \_\_\_\_\_

Intraocular Right \_\_\_\_\_ mmHg Tension Left \_\_\_\_\_ mmHg

Remarks: \_\_\_\_\_

\_\_\_\_\_ Motility Normal

\_\_\_\_\_ Motility Abnormal

\_\_\_\_\_ Binocular Vision Normal

\_\_\_\_\_ Binocular Vision Abnormal

Slit Lamp Exam:

	Normal	Abnormal	
	Right/ Left	Right/Left	Specify Abnormalities
Conjunctiva _____	/	/	Iris/Pupil _____
Cornea _____	/	/	Lens _____
_____	/	/	Eyelids _____
_____	/	/	_____

Indirect ophthalmoscopy with scleral depression (Dilated Pupil):

	Normal	Abnormal	
	Right/Left	Right/Left	Specify Abnormalities
Disc _____	/	/	
Macula _____	/	/	
Lens _____	/	/	
Peripheral Retina _____	/	/	

Examining Physician:

Based on your personal observation and review of the test results and considering Tennessee Athletic Commission rules, is it your medical opinion that this applicant is physically fit to be licensed and compete in combative sports? [ ] Yes [ ] No If no, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Licensed Physician's Name \_\_\_\_\_

Medical License Number \_\_\_\_\_

Applicant/Patient Name \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date/ Time \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date/ Time \_\_\_\_\_



**Professional Combatant Physical Examination**

A licensed Nurse Practitioner or Medical Doctor must conduct this examination and complete this form. Please complete this form in its entirety. Participant's Full Name:

\_\_\_\_\_

First Name Middle Name Last Name

**PHYSICAL HISTORY:** Please check all that apply:

- Asthma  Blood in urine  Allergies  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
- If you checked any box, please explain below:

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Have you ever undergone any type of surgery? \_\_\_\_\_ Yes \_\_\_\_\_ No (State with specificity what type and when):

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

**General appearance:** \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Temperature \_\_\_\_\_  
\_\_\_\_\_ Disabling scars \_\_\_\_\_ Mouth \_\_\_\_\_ Teeth \_\_\_\_\_  
\_\_\_\_\_ Tonsils \_\_\_\_\_ Neck \_\_\_\_\_  
\_\_\_\_\_ Pulse at rest \_\_\_\_\_ Pulse after 100 hops \_\_\_\_\_  
\_\_\_\_\_ Blood pressure at rest \_\_\_\_\_ Blood pressure after 100 hops \_\_\_\_\_  
\_\_\_\_\_ Blood pressure two (2) minutes later \_\_\_\_\_

Enlarged glands: [ ] Yes [ ] No                      Goiter: [ ] Yes [ ] No

Heart: Pulse rhythm [ ] Regular [ ] Irregular      Murmurs: [ ] Yes [ ] No

Musculoskeletal system: \_\_\_\_\_

Apical impulse: [ ] Heavy [ ] Normal                      Enlargement: [ ] Yes [ ] No

Lungs: Rales [ ] Yes [ ] No                      Abdomen: Enlargement of liver [ ] Yes [ ] No

Breasts: Mass [ ] Yes [ ] No [ ] Not Applicable                      Tenderness [ ] Yes [ ] No

Discharge: [ ] Yes [ ] No                      Enlargement of Spleen: [ ] Yes [ ] No

Hernia: [ ] Yes [ ] No                      Testicles: Normal [ ] Yes [ ] No [ ] Not Applicable

Reflexes: Pupils \_\_\_\_\_ Knee jerks \_\_\_\_\_ Romberg \_\_\_\_\_ Babinski \_\_\_\_\_

Skin: Tone \_\_\_\_\_ Rash \_\_\_\_\_ Boils \_\_\_\_\_ Other \_\_\_\_\_

Unhealed wounds: \_\_\_\_\_

Remarks: \_\_\_\_\_

**Examining Physician:**

Based on your personal observation and review of the test results and considering Commission rules, is it your medical opinion that this applicant is physically fit to be licensed to compete in combative sports? [ ] Yes [ ] No If no, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Licensed Nurse Practitioner/ Physician's Name \_\_\_\_\_

Medical License Number \_\_\_\_\_

Nurse Practitioner/Physician's Signature

Date/ Time



## Authorization to Use and Disclose Protected Health Information

I hereby authorize \_\_\_\_\_ (Nurse Practitioner/ Medical Physician) to furnish to the Tennessee Athletic Commission (the "Commission"), or its successors, copies of all my medical records, hospital records, records of treatment for drug and/or alcohol abuse or dependency, or other information requested by the Commission in connection with my application for licensure by the Commission or any further or future investigation by the Commission necessary to determine my fitness for licensure.

I further authorize the Commission or its successors to release any medical or other personal information with respect to my application or licensure to those athletic commissions (or similar regulatory bodies) that have a need to know, as determined by the Commission. This disclosure of records is required for official use, including investigation of my fitness for licensure by the Commission. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to receive a copy of this authorization if I request it. I may inspect or obtain a copy of the protected health information that I am being asked to disclose. I understand that I have a right to revoke this authorization by sending written notification to the Tennessee Athletic Commission, 500 James Robertson Parkway, Nashville, TN 37243. I understand that if I revoke this authorization, I may not be allowed to continue in the licensure process, or, if I am licensed, my license may be adversely affected.

This authorization shall remain valid for two (2) years from the date a license is issued to me. A copy of this authorization shall be as valid as the original.

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date