Fighter's Passport

Name: ____

Address: ____

Home phone: ___________________________ **Work phone:** __________________________

Date of birth: ____________________________ **Occupation:** __________________________

Sex: **Male** **Female**

Email: ____

Contact in Case of Emergency

Name: ____

Phone number: _____________________ Relation: ___________________________

Family physician

Name: ____

City: ________________________ Phone number: _______________________

Body Composition Assessment

Height: (cm)	Height: (Inches)	**Athlete Photo Here:**
Weight: (kg)	Weight: (lbs)	
Resting Blood Pressure (BP): Systolic _____ mmHg	Resting Blood Pressure (BP): Diastolic ____ mmHg	
Resting Heart Rate (HR): ______ bpm		

Existing Medical Conditions

Please check the appropriate conditions.

_____ Anemia
_____ Arthritis
_____ Asthma
_____ Cholesterol
_____ Diabetes
_____ Epilepsy
_____ Heart condition
_____ Hernia

_____ Obesity
_____ Pregnancy
_____ Thyroid problem
_____ Ulcer
_____ Other
____
____

Medications

Are you currently taking any medications? **_____ YES** **_____ NO**

If yes, please list the medication and for what condition.

Medication ____________________________________ Condition ____________________________________
Medication ____________________________________ Condition ____________________________________
Medication ____________________________________ Condition ____________________________________
Medication ____________________________________ Condition ____________________________________

Allergies

Do you have any allergies? **_____ YES** **_____ NO**

If yes, please list & indicate if medication is required.

Allergy ____ Medication __________________________________
Allergy ____ Medication __________________________________

Injuries

Do you have any pain or have you injured any of the following areas?

_____ Head
_____ Neck
_____ Body
_____ Back: U/L
_____ Hip: R / L

_____ Shoulder: R / L
_____ Elbow: R / L
_____ Wrist: R / L
_____ Knee: R / L
_____ Ankle: R / L

Please explain: ____

Fighter Class and Record

Fighter Class: ____________________________

Date	Tournament	Tournament Record	Overall Record

Injury Record

Date	Type of Injury	Authorizing Official	Doctors Signature