Reset Form

PHYSICAL EXAMINATION REPORT FOR BOXER OR UNARMED COMPETITOR

State Form 54475 (10-10)
INDIANA GAMING COMMISSION

INSTRUCTIONS: This completed report must be sent to the Athletic Division. Other types of physical examination reports will no longer be accepted. Examinations can be emailed to iac@igc.in.gov, faxed to (317) 233-0047, or mailed to:

Indiana Gaming Commission
Attention: Athletic Division
101 W. Washington Street
East Tower, Suite 1600
Indianapolis, Indiana 46204

FIGHTER INFORMATION
(*to be completed by fighter*)

Full name of applicant (*first, middle, last*)	Date of birth (*month, day, year*)

Address (*number and street, city, state, and ZIP code*)

Primary telephone number ( )	Business telephone number ( )

Sex ☐ Male ☐ Female	Height	Weight

MEDICAL HISTORY
(*to be completed by fighter*)

Has individual ever had any of the following conditions:

☐ Fainting spells	☐ Rupture (hernia)	☐ Chest pains	☐ Operations
☐ Shortness of breath	☐ Swollen joints	☐ Spitting of blood	☐ Diabetes
☐ Frequent headaches	☐ Convulsions (fits)	☐ Chronic cough	☐ Rheumatism
☐ Bleeding disorder	☐ Asthma	☐ Allergies	☐ Double vision
☐ Palpitations (racing heart rate)		☐ Cerebral hemorrhage or any other serious head injury	

Number of knockouts received: _____ Date of last knockout (*month, day, year*): _____

Longest duration of unconsciousness: _____

Length of time before resuming boxing or unarmed combat after last knockout: _____

Ever knocked unconscious in other sport or in any other way? ☐ Yes ☐ No
If yes, explain:

Amateur boxing record	Wins _____	Losses _____	Draws _____
Professional boxing record	Wins _____	Losses _____	Draws _____
Amateur unarmed combat record	Wins _____	Losses _____	Draws _____
Professional unarmed combat record	Wins _____	Losses _____	Draws _____

AFFIRMATION
(*to be completed by fighter*)

I hereby swear or affirm, under penalties of perjury, that the statements made in this report are true, complete, and correct.

Signature of fighter	Printed name of fighter	Date (*month, day, year*)

PHYSICAL EXAMINATION
(*to be completed by examining physician*)

Pulse at rest: _____ Pulse after 100 hops: _____

Blood pressure at rest: _____ Blood pressure after 100 hops: _____

Glands
Enlarged? ☐ Yes ☐ No Goiter ☐ Yes ☐ No

Heart
Pulse rhythm ☐ Regular ☐ Irregular Apical impulse ☐ Heavy ☐ Normal
Enlargement? ☐ Yes ☐ No Murmurs? ☐ Yes ☐ No

Lungs
Rales? ☐ Yes ☐ No

Breasts
Mass? ☐ Yes ☐ No Tenderness? ☐ Yes ☐ No Discharge? ☐ Yes ☐ No

Abdomen
Enlargement of liver? ☐ Yes ☐ No Enlargement of spleen? ☐ Yes ☐ No
Hernia? ☐ Yes ☐ No If yes: ☐ Femoral ☐ Inguinal ☐ Ventral
Remarks:

Testicles
Normal? ☐ Yes ☐ No
Remarks:

Reflexes
Pupils: _____ Knee jerks: _____ Romberg: _____ Babinski: _____

Skin
Rash: _____ Boils: _____ Any other unhealed wounds: _____

Remarks for specified medical clearances:

Medications:

Physician MUST check one of the boxes below:

☐ **I HAVE** ☐ **I HAVE NOT**

medically cleared this fighter to compete in boxing and/or unarmed combat.

Physician's signature	Physician's name and license number	Date (*month, day, year*)
Physician's business address (*number and street, city, state, and ZIP code*)		Business telephone number ( )