**Texas Department of Licensing and Regulation**


## Compliance Division/COMBATIVE SPORTS PROGRAM

# P.O. Box 12157 Austin, Texas 78711 (512)463-5101 (800)803-9202 FAX (512)463-1087

**E.O. Thompson Building, 920 Colorado, Austin, TX 78701**

**Email Address:** combative.sports@*tdlr.texas.gov* **Internet Address:** [www.tdlr.state.tx.us](http://www.tdlr.state.tx.us)

**AMATEUR COMBATIVE SPORTS CONTESTANT REGISTRATION**

**(Including Physical Exam & Eye Exam)**

**Submit All medical exams & test results with this registration**

**PLEASE PRINT CLEARLY**

**First Name, Middle Name, Last Name (MUST BE LEGAL NAME)**

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**Mailing Address**

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**City, State, Zip**

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**Home Phone (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Foreign Nationals may submit Passport #)

**Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(City & State or Country if not U.S. Citizen)

**Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Event Information: 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 registration may result in sanctions up to and including denial or revocation of the registration.**

**Contestant Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 a nurse practitioner will NOT be accepted**

**Medical Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you taking any medication? \_\_ YES \_\_ NO; EXPLAIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Previous Hospitalization(s) or surgery (Give dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Results of the following blood tests must be attached to this application:**

* Hepatitis B surface ANTIGEN
* Hepatitis C ANTIBODY
* HIV ANTIBODY

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

**Answer All Questions Below:**

**(A) BLEEDING TENDENCIES YES NO (L) SEIZURES AND CONVULSIONS YES NO**

**(B) DIABETES YES NO (M) ASTHMA YES NO**

**(C) HERNIA YES NO (N) HIGH BLOOD PRESSURE YES NO**

**(D) HEART DISEASE YES NO (O) TUBERCULOSIS YES NO**

**(E) SICKLE CELL DISEASE YES NO (P) MONONUCLEOSIS YES NO**

**(F) KIDNEY DISEASE YES NO (Q) RHEUMATIC FEVER YES NO**

**(G) HEPATITIS YES NO (R) COUGH YES NO**

**(H) SKIN DISEASE YES NO (S) PSYCHIATRIC PROBLEMS YES NO**

**(I) HEADACHES YES NO (T) CONTACT LENSES YES NO**

**(J) JOINT INJURY OR DISLOCATION YES NO (U) NUMBER OF TIMES KO'D \_\_\_\_\_\_\_**

**(K) CONCUSSION/UNCONSCIOUSNESS YES NO (V) KIDNEY, LUNG, TESTICLE, EYE REMOVED YES NO**

(circle all requiring a YES response)

**Do you have any other information concerning your health, past or present, which is NOT COVERED by the questions above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**A PERSON AGE 36 OR OLDER MUST ALSO SUBMIT A FAVORABLE:**

* **EEG (Electroencephalography) AND**
* **EKG (Electrocardiogram)**

**EXAMINING MD or DO NAME (Please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL LICENSE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Must be licensed in a State, District or Territory of the United States)**

**ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STATE \_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MD or DO SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONTESTANT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONTESTANT NAME (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AMATEUR CONTESTANT'S MEDICAL EXAMINATION - PART 2**

**EARS**

 **AUDITORY CANALS RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_\_\_**

**DRUMS RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_\_\_**

**AUDITORY ACUITY FOR CONVERSATIONAL VOICE RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_\_\_**

**NOSE (note deformity, old fractures, deviated septum, other)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OROPHARYNX**

 **TONSILS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GUM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TEETH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **TONGUE (record any deviation or tremors) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **NECK (note masses, pulse, thyroid, carotid, bruits, and limitation of motion)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THORAX**

 **LUNGS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **HEART (size, murmurs, arrhythmia) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **HEART RATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BLOOD PRESSURE (S) \_\_\_\_\_\_\_\_\_\_ (D) \_\_\_\_\_\_\_\_\_\_\_\_\_**

 **PULSE RATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IMMEDIATELY AFTER 20 HOPS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **2 MINUTES AFTER EXERCISE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ABDOMEN**

 **NOTE SCARS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **LIVER, KIDNEY, SPLEEN (enlarged, tender) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **INGUINAL AREA (tenderness, hernia) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SKIN (note staph infection, cyanosis, hair distribution)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LYMPHATIC SYSTEM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MUSCULOSKELETAL SPINAL SYSTEM (curvature, posture, tenderness, limitation of motion)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EXTREMITIES (deformity, tenderness, joint mobility) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NEUROLOGICAL**

 **GAIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RHOMBERG \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **FINGER TO NOSE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ KNEE JERKS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **BICEP JERKS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BABINSKI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **BRUDZINSKI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CRANIAL NERVES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **OTHER NEUROLOGICAL ABNORMALITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I hereby certify that I have examined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 (Please print contestant’s name)

**Date of the exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Month Day Year**

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

**MD or 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**

**VISUAL ACUITY N \_\_\_\_\_\_\_\_\_ N \_\_\_\_\_\_\_\_**

**(WITHOUT CORRECTION)**

 **F \_\_\_\_\_\_\_\_\_ F \_\_\_\_\_\_\_\_**

**EXTERIOR EXAM \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**ANTERIOR EXAM \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**FUNDI \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**EXTRAOCULAR MUSCLES \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**VISUAL FIELDS (Confrontation) \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**TONOMETRY \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**EXPLAIN ABNORMAL FINDINGS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**DIAGNOSIS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**I hereby certify that I have examined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 (Please print contestant’s name)

**Date of the exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Month Day Year**

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

**Ophthalmologist or Optometrist NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 (Please print)

**LICENSE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Must be licensed in a State, District or Territory of the United States)**

**ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STATE \_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OPHTHAMOLOGIST or**

**OPTOMETRIST SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONTESTANT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**