



# Lethbridge Combative Sports Commission

## Combatant Package

**In an effort to standardize and streamline the process for medical requirements and approvals for a Combatant to participate in an Event in Lethbridge, the Lethbridge Combative Sports Commission has developed the following guidelines/instructions and forms:**

### **A) Medical Forms:**

1. Print out the Medical History Form and the Physician's Registration Exam Form. This document is a two-sided form but can be printed out separately.
2. The Medical History Form is to be completed by the Combatant and then taken to their Family Physician along with the Physician's Registration Exam Form.
3. The Physician will complete the Physician's Registration Exam Form and will attach the required results of all Medical Tests, Imaging and Blood Work. **Unless specifically requested by the Commission, Combatants under the age of 40 years do not require a CT scan, EKG, Ophthalmologic Examination or Neurological Examination.**
4. The forms and all relevant results will be forwarded to the Promoter and as soon as possible, be made available to the Lethbridge Combatant Sports Commission for their review.
5. The Medical History and the Physician's Registration forms are only valid for the specific Event the Combatant is scheduled to participate in. These forms must be dated within **120 Calendar Days** of the scheduled Event date.
6. Blood Work results are valid for **twelve (12) months** prior to the scheduled Event date.
7. Pregnancy tests must be dated no longer than **SEVEN (7) Calendar Days** prior to the scheduled Event date.
8. All medical results must be submitted at least **SEVEN (7) Calendar Days** prior to the scheduled Event date.
9. Combatants who are 40 years and older will be required to obtain the following additional medical testing:

a. Initial testing should include:

Magnetic Resonance Angiogram (MRA) of Brain.

b. Annual testing must include the following:

- Magnetic Resonance Imaging (MRI) of the Brain without contrast.
- Electrocardiogram (EKG).
- Cardiac testing that provides both myocardial perfusion and echocardiographic structural assessment. An exercise stress echocardiogram is the recommended method. However, a combination of an echocardiogram in addition to another form of cardiac stress testing may be acceptable.
- Annual formal neurocognitive testing, with a notation of any deterioration from the baseline (first) assessment.
- Blood work including a complete blood count (CBC) and complete metabolic panel (CMET) which includes hepatic tests, blood urea nitrogen, creatinine and glucose.
- Ophthalmologic eye exam with pupil dilation and retinal examination.

## **B) Waiver:**

1. Read the waiver.
2. Fill out the waiver form. Initial each paragraph, sign and date the form.
3. The waiver should be returned to the Lethbridge Combative Sports Commission at least seven (7) days prior to the weigh in date. The waiver can be scanned and emailed to [lcscom18@gmail.com](mailto:lcscom18@gmail.com) or sent to the promoter who will forward the form to the Commission. **Photographs of documents will not be accepted.**

## **C) Coaches/Cornermen**

1. Fill out the Coaches/Cornermen form.
2. Each Combatant can have up to three (3) in their corner. The coaches and cornermen will fall under the combatant's registration and will be subject to the Commission's rules and regulations.
3. This form should be returned with the waiver.



## Lethbridge Combative Sports Commission

### COMBATANT MEDICAL HISTORY FORM: BOXING/MIXED MARTIAL ARTS

Legal Name: \_\_\_\_\_  
Last
First
Middle

Address: \_\_\_\_\_  
Street
City
Prov
Country

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  M  F Emergency Contact/Phone#: \_\_\_\_\_ Event Date: \_\_\_\_\_

**Health History -- This section is to be completed by the Combatant.**

Do you have, or have you ever had any of the following?

	Yes	No		Yes	No
Seizure, flashing lights	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Headaches or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	Fractures/sprains/cuts	<input type="checkbox"/>	<input type="checkbox"/>
Passed out during exercise	<input type="checkbox"/>	<input type="checkbox"/>	Neck or spine injury	<input type="checkbox"/>	<input type="checkbox"/>
Double or blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
LASIK, PRK, or other eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores, fever blisters or herpes	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hearing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Broken nose	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or liver problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke/heat exhaustion	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beat or murmur	<input type="checkbox"/>	<input type="checkbox"/>	Recent illness or fever	<input type="checkbox"/>	<input type="checkbox"/>
Muscle cramping during exercise	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell trait or disease	<input type="checkbox"/>	<input type="checkbox"/>

If "Yes" to any of the above, explain: \_\_\_\_\_

	Yes	No	
Have you ever had a concussion, a head injury, or lost consciousness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever needed surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do any diseases run in your family?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you seen a doctor for <i>any</i> medical problem in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any other medical conditions or training/sparring injuries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Women only:</i> Have you ever had any type of breast surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is there any chance you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are you allergic to any medications or supplements? \_\_\_\_\_

What medications or supplements are you taking on a regular basis? \_\_\_\_\_

What medications or supplements have you taken within the last two weeks? \_\_\_\_\_

**Sport History**

Amateur Record: \_\_\_\_\_ Pro Record: \_\_\_\_\_

Date of last bout: \_\_\_\_\_ Result: \_\_\_\_\_ Number of times knocked out: \_\_\_\_\_

Number of times knocked out in past year: \_\_\_\_\_ Date of last knock out: \_\_\_\_\_

I hereby authorize the Lethbridge Combative Sports Commission to have immediate and unlimited access to any and all medical records which may relate to my fitness to participate in boxing/mixed martial arts or are related to an injury or suspected injury sustained as a result of a boxing/mixed martial arts match. I certify that I have been training faithfully and am in good physical condition. I attest that the answers given above are true and correct to the best of my knowledge and belief. I understand that the examining physician depends on the reliability of the statements I made above, and I am not withholding any information from the examining physician. I further understand that all statements and information supplied by me, if untrue and not informative, may lead to penalty and/or suspension.

\_\_\_\_\_  
Name (printed) Signature Date

**The reverse side of this form is to be completed by the physician.**



# Lethbridge Combative Sports Commission

## PHYSICIAN'S REGISTRATION EXAM: BOXING/MMA

Legal Name: \_\_\_\_\_  
Last      FirstMiddle

Address: \_\_\_\_\_  
Street      City      Prov      Country

Date of Birth: \_\_\_\_\_ Sex:  M  F Event Date: \_\_\_\_\_

**PHYSICAL EXAM:** This section is to be completed by the examining physician.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temp: \_\_\_\_\_  Afebrile RR: \_\_\_\_\_ BP: \_\_\_\_\_/\_\_\_\_\_ HR: \_\_\_\_\_

	Normal	Abnormal		Normal	Abnormal	Deferred
<b>General</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Abd.</b> (Hernias)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEENT</b> Head	<input type="checkbox"/>	<input type="checkbox"/>	(Masses/Tenderness)	<input type="checkbox"/>	<input type="checkbox"/>	
PERRLA/EOMI	<input type="checkbox"/>	<input type="checkbox"/>	<b>Ext.</b> Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Periorbital Regions	<input type="checkbox"/>	<input type="checkbox"/>	Hands/Wrists	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/Hearing (grossly)	<input type="checkbox"/>	<input type="checkbox"/>	Duck walk	<input type="checkbox"/>	<input type="checkbox"/>	
Jaw/Oropharynx/Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<b>Skin</b> (Rashes/Lacerations)	<input type="checkbox"/>	<input type="checkbox"/>	
Nose (stability, obstruction)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Neuro.</b> Alertness/Orientation	<input type="checkbox"/>	<input type="checkbox"/>	
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Cranial Nerves (grossly)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Tandem Gait	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Vision</b> Peripheral/Fields (grossly)	<input type="checkbox"/>	<input type="checkbox"/>	Romberg/Pronator Drift	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Heart</b> Rhythm/Sounds/Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Finger to Nose	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Chest</b> Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Reflexes			
Ribs	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			

**Abnormals:** \_\_\_\_\_

<b>MEDICAL TESTING:</b>	Negative/ Normal	Positive	Not Reviewed	Not Required	Date of test/exam
Hepatitis B Surface Antigen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Hepatitis C Antibody <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
HIV Antibody or Quantitative RNA (circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
<b>CT Scan/MRI Brain (circle)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
<b>EKG</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
<b>Ophthalmologic Examination</b> (Uncorrected vision must be at least 20/60)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
<b>Neurological Examination</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Women: HCG Urine/Serum (circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____

I hereby certify that based on the statements made by the participant on the reverse side of this form, my physical findings, and pending any medical testing not yet reviewed, it is my opinion that said participant  **IS**  **IS NOT** in good physical condition and is/is not medically cleared to be licensed/registered as a competitor in boxing/mixed martial arts.

Reason not cleared for competition: \_\_\_\_\_

\_\_\_\_\_  
 Physician's Name, M.D.      Signature      Date

\_\_\_\_\_  
 Office Address      Phone      Email



## Lethbridge Combative Sports Commission

# Hold Harmless Liability and Personal Injury Waiver

Combatant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

(Initial)\_\_\_\_ - **RELEASE.** I hereby acknowledge and agree to hold harmless, not to hold liable, and not to bring any demand or commence any claim whatsoever, legal or equitable, including any claim for negligence, against the City of Lethbridge and/or the Lethbridge Combative Sports Commission or any of their respective agents, promoters, servants, employees, staff, volunteers, officials, referees, Emergency, Security & Police Personnel, Physicians and any other Medical Personnel, other combatants or participants, managers, trainers, Facility and Property owners where the said event is taking place, ("Releasees") for any injury or death, expense, loss of income or damage/destruction of property, suffered or incurred as a result of my Participation in any activity or bout organized by the above noted Releasees regardless of whether such injury and/or loss is known, unknown, or due to any cause whatsoever, including or resulting from the acts, conduct, negligence, or omissions of the Releasees. I understand that negligence includes the failure on the part of the Releasees to take reasonable steps to safeguard or protect me from the risks, dangers and hazards associated with combative sports.

(Initial)\_\_\_\_ - **ASSUMPTION OF RISK.** I, as the Athlete or Participant, fully understand that full contact combative sports are activities that inherently carry a very real and substantial risk of severe injury or death to me. I fully understand the dangerous nature of the sport and freely and fully consent to participate as a combatant/fighter in the event known as:

\_\_\_\_\_  
(event name and date)

(Initial)\_\_\_\_ - **INDEMNIFICATION.** I shall indemnify, defend, pay on behalf of and hold harmless, the Releasees, from and against all loss, claims, demands, costs (including solicitor/client costs), damages, actions, suits or proceedings arising out of, or in connection with, the activities or performance of this event by myself, my agents, representatives, employees or next of kin.

**I have read and fully understand this waiver and I have had the time and the freedom to seek legal counsel or advice prior to signing this waiver.** I am signing this waiver of my own free will without any duress or undue pressure. I acknowledge that I am in the proper physical and mental health to participate in the above-named event.

It is also my intent to have this waiver extend to my estate and to bind my heirs, executors, administrators, representatives and assigns.

Signature of Combatant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_



# Lethbridge Combative Sports Commission

## Coaches/Cornermen

Combatant's Name: \_\_\_\_\_

Each combatant can have up to three (3) coaches/cornermen at cage/ring side. The attending coaches/cornermen fall under the registration of the combatant and are subject to the rules and regulations of the Lethbridge Combative Sports Commission.

1. Name: \_\_\_\_\_

2. Name: \_\_\_\_\_

3. Name: \_\_\_\_\_