OKLAHOMA STATE ATHLETIC COMMISSION
PHYSICAL EXAMINATION FOR PROFESSIONAL WRESTLING

To Be Answered By Wrestler

1) Legal Name ___________________________ Age____

2) Have you had any serious bone or joint injuries? Yes____ No____

3) Have you ever had a concussion or head injury? Yes____ No____

4) Have you ever passed out during exercise? Yes____ No____

5) Are you currently being treated for any serious illness? Yes____ No____

6) Are you currently taking any medication on a regular basis? Yes____ No____

7) Have you ever been treated for any serious illness or surgery? Yes____ No____

Signature of Wrestler ____________________________________________________________________________
I hereby certify the above statements are true.

TO BE COMPLETED BY THE EXAMINING PHYSICIAN

EXAM MUST BE COMPLETED BY A M.D. or D.O.
UNLESS STATED, Indicate normal findings by placing a check

1) BLOOD PRESSURE:

Systolic_________ Diastolic_________

2) LUNGS, CHEST, HEART:

3) HEAD, EYES, EARS, NOSE, THROAT:

4) ABDOMEN:

5) ORTHOPEDIC:

I hereby certify that on the basis of the above participant’s statements and physicians findings, it is my opinion that this participant is in good physical condition and able to engage in professional wrestling events.

PRINTED NAME OF PHYSICIAN: ___________________________________ LICENSE NO: _________

PHYSICIAN SIGNATURE: ______________________________________ M.D. or D.O.

DATE: _______________