



OKLAHOMA
State Athletic Commission

**OKLAHOMA STATE ATHLETIC COMMISSION
PHYSICAL EXAMINATION FOR PROFESSIONAL WRESTLING**

To Be Answered By Wrestler

- 1) Legal Name _____ Age ____ Date of Birth _____
- 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 ____
- 8) Have you ever or are you currently undergoing gender reassignment? 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: _____ **of physical**

*****MUST BE SIGNED OFF BY MD OR DO **Will not be accepted if signed by only PA OR RN.**

PHYSICIAN OFFICE ADDRESS: _____

PHYSICIAN OFFICE PHONE NUMBER : _____ - _____