OKLAHOMA
State Athletic Commission

Wrestling@osac.ok.gov Fax 405-900-8383
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____
9) Have you or a family member ever been diagnosed with sickle cell disease or trait? 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, VISION, EARS, NOSE, THROAT:

4) ABDOMEN:

5) ORTHOPEDIC:

6) NEURO:

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.

PHYSICAL DATE:_____

*****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 :_____