

**Mixed Martial Arts Australasia Incorporated.**

(ABN 80 134 549 184)

P O Box 160

Albion, Qld. 4110.



**2026 COMPETITOR MEDICAL INSPECTION**

Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ P/C: \_\_\_\_\_

Proof of ID: Drivers License / Passport Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**MEASUREMENTS:**

Height (cm): \_\_\_\_\_ Weight: \_\_\_\_\_ Reach: \_\_\_\_\_

Waist (cm) \_\_\_\_\_ Chest: \_\_\_\_\_ Chest exp: \_\_\_\_\_

BP: \_\_\_\_\_ Heart Rate Resting: \_\_\_\_\_

**Have you previously or do you suffer from:**

- |                              |     |    |
|------------------------------|-----|----|
| 1) Fainting                  | YES | No |
| 2) Epilepsy                  | YES | No |
| 3) Cardiac Disorder          | YES | No |
| 4) Neurological Disorders    | YES | No |
| 5) Severe Headache           | YES | No |
| 6) Migraine                  | YES | No |
| 7) Renal or Bladder Disorder | YES | No |
| 8) Respiratory Issues        | YES | No |
| 9) Mental Illness            | YES | No |
| 10) Physical Disability      | YES | No |

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you been knocked unconscious or suffered concussion during training, competition or other in the last:**

60 Days:	YES	No	Details: _____
6 Months:	YES	No	_____
12 Months:	YES	No	_____

**REACTION/RESPONSE:**

**Good / Average / Poor**

- |                      |           |                 |           |
|----------------------|-----------|-----------------|-----------|
| 1) Head Movement     | G / A / P | 5) Visual Range | G / A / P |
| 2) Shoulder Movement | G / A / P | 6) Hearing      | G / A / P |
| 3) Hip Movement      | G / A / P | 7) Speech       | G / A / P |
| 4) Spine Movement    | G / A / P | 8) Attention    | G / A / P |

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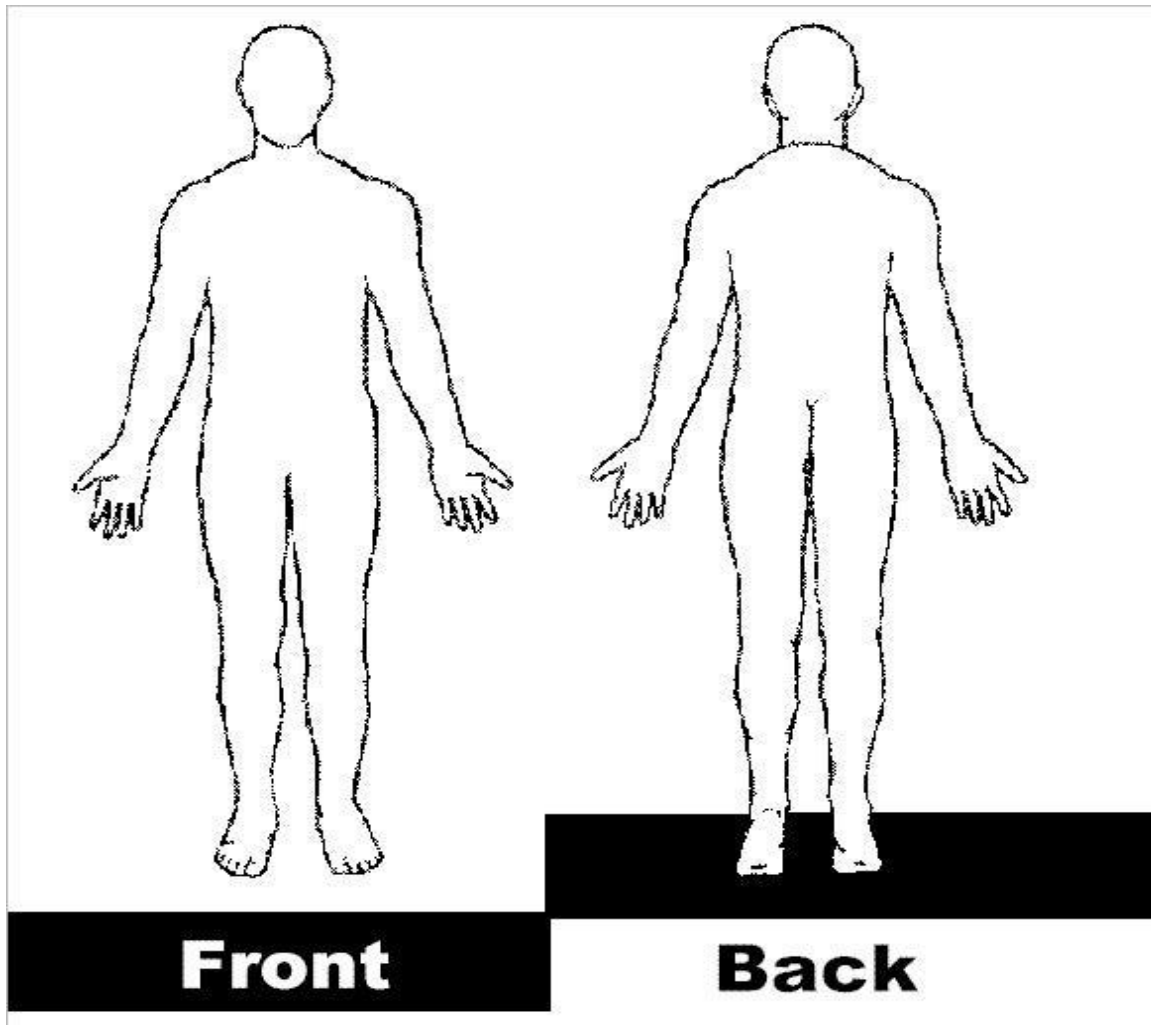
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Physical Appearance. Notable Scars/Deformities:



I, \_\_\_\_\_ consider the above named person FIT / UNFIT for competition.  
Medical Practitioner

\_\_\_\_\_  
Medical Practitioner Signature

\_\_\_\_\_  
Date



Medical Practitioner Stamp/Contact Details