Masters Medical Clearance Form

All wrestlers in Divisions C, D, E and F must present a medical clearance form at weigh-Ins that states the competitor is cleared to compete without any restriction. The medical clearance form must be dated within 90 days of competition and clearly identify the doctor with location and contact information.

USA Wrestling Event

Competition:

Place / Date:

WRESTLER

Last Name: _____ First Name: _____

Date of Birth (Month/Day/Year): ___/___/____Sex: ☐ Male ☐ Female

Address:

_____

E-mail: _____Phone Number: .....

MEDICAL ASSESSMENT SUMMARIES

1. **Medical History:**

☐ Normal ☐ Abnormal - Please specify:

_____

_____

_____

_____

2. Routine Lab Tests:

Hemoglobin, Hematocrit, Erythrocytes, Thrombocytes, Leukocytes, C-reactive Protein, Glucose, Creatinine, Uric Acid, Triglycerides, Cholesterol (total, LDL, HDL), Creatine phosphokinase, Sodium, Potassium, Calcium, Phosphor, Urine Analysis

☐ Normal ☐ Abnormal - Please specify:

3. Skin Inspection:

☐ Normal ☐ Abnormal - Please specify:

4. General Health:

☐ Normal ☐ Eligible to wrestle with considerations ☐ Non-eligible to compete

Please specify:

5. Cardiovascular Examination:

Physical examination, Chest x-ray, Heart rate & rhythm, Blood pressure, Electrocardiography, Echocardiography

☐ Normal ☐ Eligible to wrestle with considerations ☐ Non-eligible to compete

Please specify:

6. Orthopedic Examination

Spine (cervical, thoracic, lumbar), Shoulder, Arm, Elbow, Forearm, Wrist, Hand, Fingers, Hip, Thigh, Knee, Lower leg, Ankle Et Foot

☐ Normal ☐ Eligible to wrestle with considerations ☐ Non-eligible to compete

Please specify:

Examining Doctor:

Surname & Name: ..... Date: .....

Address: .....

Signature: .....

Medical Certification

I certify that this wrestler: _____

☐ Has no apparent contraindication to wrestle at a competitive level.

☐ Is not recommended to wrestle at a competitive level.

☐ Normal ☐ Eligible to wrestle with considerations ☐ Non-eligible to compete - Please specify:

_____

_____

_____

Certifying Doctor: Date: _____

First & Last Name: _____

Medical Registration Number:_____

Address: _____

Phone Number:_____

E-mail:_____

USA Wrestling Doctor Approval

☐ Medical Certificate Approved.

☐ Medical Certificate is not approved.

Date: _____

First and Last Name: _____

Signature:_____