



OPHTHALMOLOGICAL EXAM

For Professional / Amateur Boxer & Unarmed Combatant
To be performed with dilation and by a Ophthalmologist Only

Full Name: First	Middle	Last	Ringname	Telephone	Date of Birth
Address (Street)			(City)	(State)	(Zip Code)

HISTORY - If possible provide the following information:

Name and hometown of physician in charge: _____

Has applicant had any of the following conditions:

- (1) Blurred Vision? Yes _____ No _____
- (2) Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye? Yes _____ No _____
- (3) Has applicant ever been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, Primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens or cataract?
 Yes _____ No _____ if yes, please explain:

(4) Eye Disease? Yes _____ No _____
 List nature of Disease or injury: _____

(5) Eye Injury? Yes _____ No _____
 List nature of Disease or injury: _____

(6) Detached Retina surgery on either eye? Yes _____ No _____
 List which eye and when and where surgery was done: _____

EXAMINATION:

Vision Without / With Glasses

Right: _____/_____

Left: _____/_____

Remarks: _____

Refraction: If either eye is 20/40 or worse:

Right _____ Sph _____ Cyl x _____ Acuity _____

Left _____ Sph _____ Cyl x _____ Acuity _____

Intraocular Right: _____ mmHg

Tension Left: _____ mmHg

Motility Normal: ___ Abnormal: _____

Binocular Vision Normal: ___ Abnormal: _____

Slit Lamp Exam:

Normal

Abnormal

Specify Abnormalities

	Normal	Abnormal	Specify Abnormalities
	Right / Left	Right / Left	
Conjunctiva _____	____/____	____/____	_____
Cornea _____	____/____	____/____	_____
Iris/Pupil _____	____/____	____/____	_____
Lens _____	____/____	____/____	_____
Eyelids _____	____/____	____/____	_____

Indirect Ophthalmoscopy with Scleral Depression (Dilated Pupil)

Normal

Abnormal

Specify Abnormalities

	Normal	Abnormal	Specify Abnormalities
	Right / Left	Right / Left	
Disc _____	____/____	____/____	_____
Macula _____	____/____	____/____	_____
Vessels _____	____/____	____/____	_____
Peripheral Retina _____	____/____	____/____	_____

PLEASE READ AND SIGN PAGE 2



OPHTHALMOLOGICAL EXAM – Page 2

Physicians

Remarks: _____

The Burlington Brawl event shall deny, suspend, revoke or place restrictions on the fighter (Applicant) because of a medical or visual condition, included but not limited to one of the following:

- (1) *Uncorrected visual acuity of less than 20/200 in either eye, or 20/60 with both eyes;*
- (2) *Corrected visual acuity of less than 20/60 in either eye, regardless of its cause;*
- (3) *A visual field of 60 degrees or less extending over one or more quadrants of the visual field;*
- (4) *Presence or history of retinal detachment or retinal tear unless treated by an Ophthalmologist and then approved by an Ophthalmologist approved by the Burlington Brawl who then assesses that the fighter (applicant) is at no significant risk of further injury if the fight is resumed. Such assessment shall occur both within five days before, and five days after the event;*
- (5) *Presence of primary or secondary glaucoma, whether or not such condition has been treated;*
- (6) *Presence of aphakia, psuedoaphakia, dislocated lens or cataract in either eye;*
- (7) *Any other visual condition which the Burlington Brawl determines would prevent the applicant from safely engaging in combat.*

The examining physician is requested to mail a copy of any report, directly to the Burlington Brawl of an applicant that has a condition that may preclude him/her from competing.

PHYSICIAN:

I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on page one of this form and I ____ DO NOT FIND or I ____ DO FIND a condition that would preclude him/her from competing in the Burlington Brawl event as an Unarmed Combatant.

 LICENSED PHYSICIANS NAME AND LICENSE NUMBER (please print)

 PHYSICIANS SIGNATURE

 STREET ADDRESS

 DATE

 CITY STATE ZIP CODE

 PHONE NUMBER

APPLICANT:

I declare under penalty of perjury under the laws of the State of Vermont, that the foregoing information is true & correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

I further agree that a photographic copy of this Authorization shall be as valid as the original.

I further agree that this Authorization will remain valid until it expires (1) one year after the date stated on this form above:

I also understand that this Authorization is copy written and can ONLY be used for the Burlington Brawl event. Any misuse of this form can be reported to Burlington Brawl staff at burlingtonbrawl@gmail.com.

 DATE

 SIGNATURE OF APPLICANT

 LOCATION

 APPLICANT NAME (PRINTED)