**North Carolina Boxing and Combat Sports Commission**
**4235 Mail Service Center**
**Raleigh, NC 27699**
**Phone: (984) 297-1107**
**FAX: (919) 715-3065**

# DILATED EYE EXAM

NAME: Last First MI Date of Birth Age

ADDRESS: Street City State Zip Code Social Security #

**HISTORY: HAS APPLICANT HAD ANY OF THE FOLLOWING CONDITIONS:**

1 Are you experiencing any blurred vision? YES NO

2 Have you had any surgical procedures done to either eye or the tissue around the eyes other than simple sutures of the skin around the eyes? YES NO

3 Have you ever been informed by any physician that you have 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 Do you have any history of eye disease? YES NO
List Nature of Disease: _____

5 Do you currently have or have you ever had an eye injury? YES NO

List Nature of eye Injury_____

6 Have you ever had detached retina surgery on either eye? YES NO

List which eye and where and when surgery was performed: _____

_____

**The examining physician is requested to MAIL and/or FAX a copy of any report, directly to the North Carolina Boxing and Combat Sports Commission.**
**Patient's Name_____Date_____**

**EXAMINATION:**

VISION: Without With Glasses REFRACTION: If either eye is 20/40 or Worse

Right_____ Right_____Sph_____Cyl X_____Acuity_____

Left_____ Left_____Sph_____Cyl X_____Acuity_____

Intraocular Tension Right_____mmHG_____

Left_____mmHG_____

Motility Normal_____Abnormal_____

Binocular Vision Normal_____Abnormal_____

| **SLIT LAMP EXAM** | **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** |
|---|---|---|---|
| | Right / Left | Right / Left | |
| Disc_____ | _____ | _____ | _____ |
| Macula_____ | _____ | _____ | _____ |
| Vessels_____ | _____ | _____ | _____ |
| Peripheral Retina_____ | _____ | _____ | _____ |

# PHYSICIAN:

I HAVE READ THE ABOVE CRITERIA AND IN ACCORDANCE WITH THE VISION REQUIREMENTS AS STATED THEREIN, HAVE EXAMINED THE APPLICANT NAMED ON THIS FORM.

***** I ☐ DO NOT FIND ☐ DO FIND** A CONDITION THAT WOULD PRECLUDE THEM FROM BEING LICENSED TO PARTICIPATE IN BOXING, KICKBOXING, TOUGHMAN, MIXED MARTIAL ARTS OR ANY TYPE OF STRIKING SPORT.

**Print Physician's Name** **Date of Exam** **Physician's License #**

**Physician's Signature** **Phone**

The North Carolina Boxing and Combat Sports Commission shall deny, suspend, revoke or place restrictions on the license of any applicant applying for a professional license to participate in boxing, kickboxing, toughman or any striking sport regulated by the North Carolina Boxing and Combat Sports Commission, because of any medical or visual condition, including but not limited to the following:

1. Is found to have any blindness or whose vision is so poor as to cause significant health hazard or impairment to his ability to effectively participate in a match;
2. Presence or history of retinal detachment or retinal tear unless treated by an ophthalmologist
   And then approved by an ophthalmologist specified by the Boxing Commission who then assess that the applicant is at no significant risk of further injury to the retina if participation in any of the sports regulated by the Boxing Commission. Such assessment shall occur both within 5 days before and 5 days after any contest.
3. Presence of primary or secondary glaucoma, whether or not such condition has been treated.
4. Presence of aphakia, pseudophakia, dislocated lens or cataract in either eye.
5. Any other visual condition which the North Carolina Boxing and Combat Sports Commission determines would prevent the applicant or licensee from safely participating in any of the combat sports regulated by the Boxing Commission.

# Applicant/Boxer:

I declare under penalty of perjury under the laws of the State of North Carolina that the foregoing information is true and correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license. I hereby **AUTHORIZE** the North Carolina Boxing Commission and or any physician employed by The North Carolina Boxing and Combat Sports Commission to **RELEASE** any and all medical information and /or personal information with respects to my status and licensure as a professional athlete which may contain any of the Boxing Commission's records. I further authorize the Boxing Commission to **RELEASE** this information to any person whom the Boxing Commission determines has a need to know. I **AGREE** that I will fully cooperate with the North Carolina Boxing and Combat Sports Commission in making my medical history available including but not limited to giving oral or written reports to the Boxing Commission regarding my medical condition, care, and/or treatment. I further **RELEASE, PROMISE TO HOLD HARMLESS, AND COVENANT NOT TO SUE** the North Carolina Boxing and Combat Sports Commission or any representative of the Boxing Commission on the basis if its attempts to obtain any of the foregoing information, and I further **RELEASE, PROMISE TO HOLD HARMLESS, AND COVENANT NOT TO SUE** any persons, firms, institutions or agencies providing such information to representatives of the Boxing Commission on the basis of its disclosures. I have signed the release voluntary and of my own free will. I further agree that a photographic copy of this **AUTHORIZATION** shall be valid as the original.

Print Name_____

Boxer's Signature_____