



New York State Athletic Commission

New York State
Department of State
State Athletic Commission
123 William Street
New York, NY 10038-3804
Telephone: (212) 417-5700

PRE-FIGHT OPHTHALMOLOGIC EVALUATION FORM

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____

Country: _____ Phone: _____

Applicant History

Has the applicant ever had any of the following conditions?

1) Blurred vision? Yes No

2) Surgical eye procedures? Yes No

If yes, please explain: _____

3) Significant eye problem or injury? Yes No

If yes, please explain: _____

4) Eye disease? Yes No

If yes, please explain: _____

5) Detached retina? Yes No

If yes, please explain: _____

6) Lasik, RK or PRK corrective procedure? Yes No

If yes, please explain: _____

7) Recent eye injury? Yes No

If yes, please explain: _____

OPHTHALMOLOGIC EXAMINATION

**Values for uncorrected vision must be completed. If vision is less than 20/40 uncorrected- either eye, a corrected vision is required.

Uncorrected Vision: OD: ____/____ OS: ____/____ OU: ____/____

Corrected Vision: OD: ____/____ OS: ____/____ OU: ____/____

Circle normal or abnormal for each

Slit lamp exam: OD: normal/abnormal OS: normal/abnormal

Dilated pupil: OD: normal/abnormal OS: normal/abnormal

Light reflex: OD: normal/abnormal OS: normal/abnormal

Accommodation reflex: OD: normal/abnormal OS: normal/abnormal

Fundi exam: OD: normal/abnormal OS: normal/abnormal

Disc: OD: normal/abnormal OS: normal/abnormal

Macular: OD: normal/abnormal OS: normal/abnormal

Cataracts: OD: present/absent OS: present/absent

Motility: OD: normal/abnormal OS: normal/abnormal

Binocular vision: OD: normal/abnormal OS: normal/abnormal

Nystagmus: Yes: No:

Intraocular pressure: OD: OS:

Comments:

Based on this exam, the fighter: is is not medically cleared to participate in combat sports.

If not cleared, recommendations include:

MUST BE AN M.D. OR D.O. OPHTHALMOLOGIST, OPTOMETRIST EXAM NOT ACCEPTED

Today's Date: _____

Physicians Name (PRINT or Stamp): _____

Physician Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Country: _____ Phone: _____

Email: _____