

FIGHT OVERVIEW - MEDIC FORM

Date of Event: ____/____/____ Name of Event: _____ Location: _____

Fighter's Full Name: _____ Corner: Red Blue Bout #: _____

TO BE COMPLETED BY MEDICAL STAFF

Injuries sustained during bout: _____

POST FIGHT OVERVIEW:

Notes: _____

Eyes: _____

Response: _____

Glasgow Coma Scale: _____

(Under 15 does not fight)

EVALUATION OUTCOME

[] *"The fighter listed above has passed the post-fight evaluation and is released."*

[] *"The fighter listed above was unable to pass the post-fight evaluation and cannot compete again until suspension is completed."*

Medics Signature: _____ Date: _____