

Ohio Athletic Commission

**PHYSICIAN RELEASE FORM TO COMPETE WITH  
SKIN RASH OR LESION**

Date of Exam: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Diagnosis: \_\_\_\_\_

Location and number of lesion(s): \_\_\_\_\_

Medication(s) used to treat lesion(s): \_\_\_\_\_

Date Treatment started: \_\_\_/\_\_\_/\_\_\_

Earliest date to participate: \_\_\_/\_\_\_/\_\_\_

Physician Name (Printed or Typed): \_\_\_\_\_ MD or DO

Office Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

**\*The attending Ringside or cageside Physician may overrule the diagnosis of the signing Physician's release form for a fighter to compete with a particular skin condition**