

THIS FORM IS TO BE COMPLETED ONLY BY A LICENSED PHYSICIAN – A MEDICAL DOCTOR, & NOT BY A NURSE PRACTITIONER
This form is valid for 60 days from the date the doctor did the medical.
The following WILL require further medical approval:

- 1. If vision is less than: worse eye 20/200 best eye 20/120 w/o lens will require a written ophthalmologist approval. Persons that suffered retinal detachment CAN NOT BOX.
2. Any form of epilepsy will require a written neurologist approval.

NAME _____ DOB _____
(MONTH DAY YEAR)

WEIGHT _____ LBS _____ KILOS HEIGHT _____ FEET _____ INCHES _____ METERS
DOCTOR, PLEASE WRITE WEIGHT IN POUNDS PLEASE WRITE HEIGHT IN FEET & INCHES

IS THERE ANY ABNORMALITY IN HEART, CHEST, BLOOD PRESSURE OR C.N.S.? _____

CHEST X-RAY REQUIRED ONLY IF THERE IS A FAMILY HISTORY OF T.B. _____
EXPIRATION _____ INSPIRATION _____

IS THERE A HERNIA, UNDESCENDED TESTIS, ORGANOMEGALY, CRYPTORCHIDISM? _____

URINALYSIS (LABETIX): SUGAR _____ PROTEIN _____ BLOOD _____

VISION: RIGHT EYE 20/_____ LEFT EYE 20/_____ COLOUR VISION:_____ FIELD OF VISION _____

EARS: (STATE OF T.M.S. & DEGREE OF DEAFNESS) _____ TEETH, BRACES, BRIDGES, DENTURES _____

**** THIS SECTION FOR FEMALES ONLY ****
ADDITIONAL FOR THE FEMALE BOXER: NOTE: CONFIRMED PREGNANCY DISQUALIFIES FROM BOXING.
ARE THERE BREASTS LESIONS, BLEEDING, MASSES OR OTHER DYSFUNCTION, PAIN? _____
LOWER PELVIC PAINS? _____ ABNORMALITY IN MENSTRUAL PATTERN? _____
AMENORRHEA? _____
SIGNATURE OF FEMALE BOXER.....

I CERTIFY THAT THE ABOVE APPLICANT IS IS NOT PHYSICALLY FIT TO ENGAGE IN COMPETITIVE BOXING: (PLEASE CIRCLE ONE OF THE ABOVE)

TO-DAYS DATE _____ PHYSICIAN'S NAME _____
ONLY A LICENSED PHYSICIAN/NOT A NURSE PRACTITIONER

PHYSICIAN'S STAMP ADDRESS _____
CITY: _____
PHONE _____ LIC# _____

**NOTE: Doctors are in great demand for the boxing program. They insure safety & assist in prevention of injuries. If you are interested in the safety of the athletes & would be available to assist in your profession for medicals or during competitive boxing, please indicate here. Keeping boxing as safe as possible is our goal.
Yes No
(CIRCLE ONE ONLY)

OBA, 3863 NORTHWOOD DRIVE, NIAGARA FALLS, ONT. L2H 2Y5

1. THIS FORM IS GOOD FOR 60 DAYS FROM THE DATE OF THE DOCTOR'S SIGNATURE.
2. THIS FORM IS TO BE COMPLETED BY THE ATHLETE & IF THE ATHLETE IS 18 YEARS OR YOUNGER, PARENTAL OR GUARDIAN SIGNATURE OF CONSENT IS REQUIRED.

PRINT....DO NOT WRITE

NAME: _____

PHONE: _____

ADDRESS: _____

CITY: _____

TO-DAYS DATE: _____

DATE OF BIRTH: _____

IF THE APPLICANT HAD OR HAS ANY OF THE FOLLOWING ILLNESSES, COMPLETE & LIST PARTICULARS OR ATTACH AN EXPLANATION TO THIS SHEET LISTING PARTICULARS. IS THERE ANOTHER SHEET ATTACHED TO THIS MEDICAL FORM? **YES NO** (CIRCLE ONE)

YOU MUST WRITE THE YEAR OF THE EVENT IN THE APPROPRIATE SPACE.

	QUESTION	YEAR	YES	NO	EXPLAIN
1	Ever been unconscious ?				
2	If you have allergies – list them .				
3	Do you have any dentures or capped teeth?				
4	Are you current with vaccinations? Tetinus? Hep B?				
5	Have you had any broken bones, dislocations, sever sprains?				
6	Have you suffered any acute infections?				
7	Have you any eye or ear impairment or infections or injuries to either?				
8	If you had any operations list them, but do not include tonsillitis or circumcism or abortions.				
9	Suffer from diabetic mellitus? (diabetes)				
10	Have you had, or do you have T.B., pleurisy, or asthma?				
11	Do you have a kidney or urine disorder, or only one kidney?				
12	Do you suffer from stomach/bowel or g.i. disorder?				
13	Do you have a cardiac (heart) condition?				
14	Have you suffered from rheumatic fever, head injury, or epilepsy?				
15	Any other important conditions?				

HAVE YOU EVER BEEN SUSPENDED FROM A COMBAT SPORT LIKE BOXING? **YES NO** (CIRCLE ONE ONLY)

EXPLAIN _____

LIST CURRENT MEDICATIONS: _____

ANY ASTHMA MEDICATION IS NOT PERMITTED TO BE USED DURING THE BOUT BUT CAN BE USED PRIOR TO THE BOUT & NOT INSIDE THE RING.

ARE THERE ANY INJURIES OR CONDITIONS THAT YOU FEEL WOULD AFFECT THE ABILITY OF THIS ATHLETE TO TRAIN, SPAR OR BOX COMPETITIVELY? **YES NO**

(CIRCLE ONE) EXPLAIN ABOVE OR ATTACH A SEPARATE SHEET

ATHLETE'S SIGNATURE _____ PARENT/GUARDIAN SIGNATURE _____

PARENTAL/GUARDIAN SIGNATURE IF ATHLETE UNDER 18 YEARS OF AGE OR A DEPENDENT