

**ATHLETE'S PORTION**

**MEDICAL FORM**

**PART 2 201.....**

**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, part 2, IS TO BE COMPLETED BY THE ATHLETE. IF THE ATHLETE IS 18 YEARS OR YOUNGER, PARENTAL OR GUARDIAN SIGNATURE OF CONSENT IS REQUIRED.**

**PRINT**

**NAME** \_\_\_\_\_ **PHONE: HOME** \_\_\_\_\_ **CELL** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY** \_\_\_\_\_

**TO-DAYS DATE** \_\_\_\_\_ **DATE OF BIRTH -MONTH** \_\_\_\_\_ **DAY** \_\_\_\_\_ **YEAR** \_\_\_\_\_

**IF THE APPLICANT HAD OR HAS ANY OF THE FOLLOWING ILLNESSES, LIST PARTICULARS OR ATTACH AN EXPLANATION TO THIS SHEET LISTING PARTICULARS. IS THERE ANOTHER SHEET ATTACHED TO THIS MEDICAL FORM? YES NO (CIRCLE ONE)**  
**IF THE APPLICANT HAS HEPATITIS C, AIDS OR ANY OTHER TYPE OF BLOOD DISORDER, THEY MAY NOT BECOME A MEMBER.**

QUESTION	YEAR	YES	NO	EXPLAIN
1 Ever been <b>unconscious</b> ?				
2 If you have allergies – <b>list them.</b>				
3 Do you have any dentures or capped teeth?				
4 <b>Are you current with vaccinations? Tetanus? Hep B?</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, <b>but do not include tonsillitis or circumcision or abortions.</b>				
9 Suffer from diabetes mellitus? ( <b>diabetes</b> )				
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 <b>cardiac</b> (heart) condition?				
14 Have you suffered from <b>rheumatic fever, head injury, or epilepsy?</b>				
15 <b>Are there any other important conditions?</b>				<i>DESCRIBE:</i>
16 <b>If female with breast implants, you can not box.</b>				

**HAVE YOU EVER BEEN SUSPENDED FROM A COMBAT/CONTACT SPORT? YES NO (CIRCLE ONE ONLY)**  
**EXPLAIN** \_\_\_\_\_

**LIST CURRENT MEDICATIONS:** \_\_\_\_\_

**ANY ASTHMA MEDICATION IS NOT PERMITTED TO BE USED DURING THE BOUT OR THE INTERVAL BUT CAN BE USED PRIOR TO THE BOUT BUT 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** \_\_\_\_\_

**ATHLETE'S SIGNATURE** \_\_\_\_\_ **PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_  
*PARENTAL/GUARDIAN SIGNATURE IF ATHLETE UNDER 18 YEARS OF AGE OR A DEPENDENT*

THIS FORM IS TO BE COMPLETED ONLY BY A LICENSED PHYSICIAN – A MEDICAL DOCTOR.

This form is valid for **60 days** from the date the doctor signed 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 the person will require a written ophthalmologist approval. Persons that suffered retinal detachment **CAN NOT BOX**.
2. No person can be a member if they have hepatitis C, aids or any other serious blood disorder. If there is any reason to suspect a blood disorder, please have a lab test to clear this issue.
3. Any form of epilepsy will require a written neurologist approval.

**\*\*No female may box if the female has breast implants of any sort.**

**\*\*No male can box if it is determined he has a rupture.**

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 \_\_\_\_\_

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**THIS SECTION FOR FEMALES ONLY**

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IF YOU HAVE BREAST IMPLANTS, YOU ARE NOT ALLOWED TO BOX WITH OR WITHOUT A BREAST PROTECTOR.

IF YOU BELIEVE YOU COULD BE PREGNANT, YOU CAN NOT BOX.

DO YOU BELIEVE YOU COULD BE PREGNANT? \_\_\_\_\_ LAST MENSTRUAL DATE? \_\_\_\_\_

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** \_\_\_\_\_

**PHYSICIAN'S STAMP**

**ONLY A LICENSED PHYSICIAN / NOT A NURSE PRACTICER**

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)