

CANADIAN AMATEUR BOXING ASSOCIATION

Medical Form – Part I

(Please print clearly)

Part I – (To be completed by athlete (male or female), or parent/guardian if under legal age)

Name: _____ Date of Birth _____
 Address: _____
 _____ Telephone _____
 Health Care: _____ Other (GMS, Blue Cross) _____
 Weight _____ Height _____ Boxing Club _____

If the applicant has or had any of the following illness, please give particulars in this space:

	Yes	No	
1. Eye or Ear Impairment, Infections or Injuries:	_____	_____	_____
2. Rheumatic Fever, T.B., Pleurisy or Asthma:	_____	_____	_____
3. Kidney or Urine Disorder, one Kidney:	_____	_____	_____
4. Diabetis Mellitus:	_____	_____	_____
5. Indigestion, Vomiting, Abdominal Cramps:	_____	_____	_____
6. Nervous breakdown, Head injury, Fits:	_____	_____	_____
7. Acute Infections:	_____	_____	_____
8. Fractures, Dislocations, Severe Sprains:	_____	_____	_____
9. Epilepsy, of Applicant or in Family:	_____	_____	_____
10. Any Suspensions from Boxing?	_____	_____	_____

_____ **Date** _____ **Signature of athlete** _____ **(Signature of Parent or Guardian)**

Part II – to be completed by the Physician

Note: The following may prelude from **boxing** (1) Impaired vision – worse eye less than 20/120 and better eye less than 20/160 (2) Squint (3) Recurrent Chronic Suppurative Otitis Media (4) Chest Expansion less than 2" (5) Total Deafness (6) **Albuminuria** (7) Hernia, Organomegaly or Undescended Testis (8) Heart Lesions.

WEIGHT _____ HEIGHT _____ EXPIRATION _____ INSPIRATION _____
 VISION: Right Eye 20/ _____ Left Eye 20/ _____
 COLOUR VISION: _____ FIELD OF VISION _____
 EARS: (state of T.M.S. and Degree of Deafness) _____
 TEETH (Any Braces) _____
 Is there any abnormality in Chest, Heart, B.P. or C.N.S.? _____
 Is there a Hernia, Undescended Testis, Organomegaly, Cryptorchidism? _____
 Urinalysis (Labetix): Sugar _____ Protein _____ Blood _____
 Chest X-Ray required only if there is a family history of T. B.) _____

Additional for the Female Boxer: Note: Confirmed Pregnancy disqualifies from boxing.

Are there breasts lesions, bleeding, masses, other dysfunction, pain? _____
 Abnormality in Menstrual Pattern? Amenorrhea? _____
 Lower Pelvic Pains? _____

I certify that the **is/is not** fit to engage in boxing: _____
 Physicians' Name and Licence Number _____

Address: _____ Telephone No. _____
 Signature _____ Date: _____