

Boxing Ontario Medical Form

(To be filled out by Physician. Please print clearly)



Athletes Information

Name _____ Date of Birth _____

Address _____ City _____ Province ON Postal Code _____

Telephone Number _____ Email Address _____ Club _____

Please note that medical forms submitted to Boxing Ontario that are dated 6 months or over will not be accepted!

Please note that the following may prelude from Boxing (1) Impaired Vision – worse eye less then 20/120 and better eye less then 20/60 (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 _____ / _____ Left Eye _____ / _____ **Colour Vision** _____ **Field of Vision** _____

Urinalysis (Labetix): Sugar _____ Protein _____ Blood _____

Concerns Past or Present	Yes	No	Comment
Eye or ear impairment, infections or injuries			
Rheumatic fever, TB, pleurisy or asthma. (a chest X-ray is required only if there is a family history of TB).			
Kidney or urine disorder, one kidney			
Diabetes mellitus			
Indigestion, vomiting, abdominal cramps			
Nervous breakdown, head injury, fits			
Acute Infections			
Fractures, dislocations, severe sprains			
Epilepsy, of application or in family			
Ears(state of T.M.S. and degree of deafness)			
Teeth – any braces			
Is there any abnormality in chest, heart , BP or C.N.S.			
Is there a hernia, undescended testis, organomegaly, cryptorchidism			
Have there been any medical suspensions from Boxing			

Female Specific (Please note that confirmed pregnancy disqualifies from Boxing)

Concerns Past or Present	Yes	No	Comment
Are there breast lesions, bleeding, masses, other dysfunction, pain			
Is there any abnormality in menstrual pattern? amenorrhea??			
Lower pelvic pains			

I _____ certify that _____
 (Physicians Name) (Athletes Name)
IS FIT / **IS NOT FIT** to engage in Boxing.
 (please check one)

Physicians Signature _____ **License #** _____ **Date Medical Conducted** _____ / _____ / _____
 Day Month Year

Address: _____ **Telephone Number** _____ **Fax Number** _____

Boxing Ontario Applicant Signature _____ **Date** _____
 (Parental/Guardian signature if applicant is age 17 and under)