

CANADIAN AMATEUR BOXING ASSOCIATION

Annual Medical Form

(please print clearly)

Part 1 – To be completed by athlete (male or female) or parent / guardian if under legal age

Name _____ Date of Birth _____

Address _____

_____ Tel. _____

BC Carecard # _____ Other _____

Weight _____ Height _____ Boxing Club _____

If the applicant has or had any of the following illnesses, 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. Diabetes 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 / Guardian _____

Part II – To be completed by the Physician

Note: the following may preclude from boxing: (1) impaired vision – worse eye less than 20/120 and better eye less than 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 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 breast lesions, bleeding, masses, other dysfunction, pain? _____

Abnormality in menstrual pattern? Amenorrhea? _____

Lower pelvic pain? _____

I certify that the applicant is / is not fit to engage in boxing.

Physician's name and Licence number _____

Address _____

_____ Telephone no. _____

Signature _____ Date _____