

# 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 \_\_\_\_\_