



## Boxing Canada Medical Form

To be filled out by a **Licensed Medical Physician Only (MD)**. Please print clearly.

### Athletes Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Email Address \_\_\_\_\_ Club \_\_\_\_\_

*Please note that medical forms submitted to Boxing Canada that are dated 3 months or over will not be accepted!*

Weight \_\_\_\_\_ Height \_\_\_\_\_ Expiration \_\_\_\_\_ Inspiration \_\_\_\_\_  
 (Chest dimension)

Vision: Right Eye \_\_\_\_\_ / \_\_\_\_\_ Left Eye \_\_\_\_\_ / \_\_\_\_\_  
 Urinalysis: Sugar \_\_\_\_\_ Protein \_\_\_\_\_ Blood \_\_\_\_\_

Concerns Past or Present	Yes	No	Comments
Seizure activity in last 3 years, intracranial mass lesions or bleeding			
Psychiatric disturbances, drug or alcohol abuse			
Number of Concussions and any unresolved post-concussion symptoms			
Refractive and intraocular surgery, cataract, retinal detachment			
Deafness (Not a contraindication to boxing but officials need to be aware)			
Uncontrolled diabetes mellitus or thyroid conditions			
Significant congenital/acquired cardiovascular and pulmonary abnormalities, Implantable device altering physiologic process			
Hepatomegaly, splenomegaly, ascites			
Musculoskeletal deficiencies			
Acute and chronic infections e.g. HIV, Hepatitis B/C infection			
Severe blood disorders, sickle cell disease/trait			

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

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

### Clinical Examinations

Normal/Abnormal	Comments
Myopia of more than -3.50 diopters, recorded visual acuity of uncorrected worse than 20/200 and corrected worse than 20/60	
Exposed open infected skin lesions/disease	
Eye, ears, nose, throat exam	
Neurological – cranial nerves, tremors, locomotor impairment, dysarthria, balance, reflexes	
Cardiovascular – tachycardia, dysrhythmia, systolic/diastolic murmurs	
Respiratory – acute/chronic infection or dyspnea	
Abdomen – hernias, masses, deformities, tenderness, scars	
Musculoskeletal – congenital/acquired deformities, ROM, stiffness	

I \_\_\_\_\_ certify that \_\_\_\_\_  
 (Licensed Medical Physician (MD) Name) (Athletes Name)  
 IS FIT / IS NOT FIT (please circle one) to engage in Boxing.

Physicians Signature \_\_\_\_\_ License # \_\_\_\_\_ Date Medical Conducted \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Boxing Canada Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (Parental/Guardian signature if applicant is age 17 and under) DK1 1/15