The boxer who receives the Restriction Notification should be observed for the following symptoms during the twenty-four (24) hour period following the issuance of this notification. If any of the following symptoms occur, please seek immediate medical attention.

- Headache or dizziness after the bout
- Increasing drowsiness or loss of consciousness following the bout
- Repeated vomiting
- Blurred vision
- Mental confusion or irrational behavior
- Convulsive seizure
- Inability to move a limb
- Excessive restlessness
- Blood or watery fluid coming from the ears or nose
- Inability to control bodily functions

I hereby state that I have fully and completely disclosed and described every part of my medical history of which I have knowledge; further, I have fully and completely disclosed all past and pre-existing injuries, or congenital defects or any and all ailments which would potentially cause me to be unable to perform as an amateur boxer or are susceptible to being aggravated. As to all of the above, of which I have not made full and complete disclosure, I hereby, for myself, my heirs, executors and assigns, waive and release all right to and claim for damages I may or might have.

Boxer Name (Print Legibly) _____ *Membership #* _____

Boxer Signature _____ *Date* _____

Parent/Guardian Signature (if boxer is under the age of 18) _____

MEDICAL RELEASE

After the restriction period ends, the boxer must have this MEDICAL RELEASE section of the form signed by a physician that is an M.D. or D.O. BEFORE he/she will be allowed to spar or box. This MEDICAL RELEASE form must be emailed to membership@usaboxing.org and to the Registration Chair of the boxer's Local Boxing Committee (LBC), before the boxer can return to sparring or competition. Once the LBC receives the MEDICAL RELEASE, the Athlete Passbook will be returned to the boxer.

MUST BE SIGNED by the athlete's personal physician.
MUST BE LEGIBLE for boxer's restriction to be removed.

On _____, I examined _____ and find no medical
Date Name of Patient/Boxer

contraindications to his/her return to sparring or competition.

Physician comments: _____

_____

_____

_____ _____
Physician's Printed Name Physician's Signature

Physician M.D. or D.O. Credentials: _____

Address: _____

Phone Number: _____

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