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 _________

Concerns Past or Present	Yes	No	Comments
Seizure activity in last 3 years, intracranial mass lesions or bleeding			
Psychiatric disturbances, drug or alcohol abuse			
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			
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			

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

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

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**____/______/___________

Day Month Year

Address: ____ **Telephone Number**_______________ **Fax Number**___________________

Boxing Canada Applicant Signature____ Date ______________________________

(Parental/Guardian signature if applicant is age 17 and under)