CANADIAN AMATEUR BOXING ASSOCIATION

Medical Form - Part 1

(please print clearly)

Part I - (To be completed by athlete (male or female), or parenV guardian if under legal age)

Name ______________________ Date of Birth ______________

Address ______________________

______________________ Tel. ______________

OHIP ______________________ Other (GMS, Blue Cross) ______________

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. Diabetis 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 or Guardian)

Part II - to be completed by the Physicion

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 Pains? ________

I certify that the applicant ***is / is not*** *fit to engage in Boxing:*

Physician's Name and Licence Number ________

Address: ________

________ Telephone No. ________

Signature ________ Date ________