Boxing Ontario 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 ON Postal Code____________

Telephone Number________________ Email Address______________________ Club________________________

Please note that medical forms submitted to Boxing Ontario that are dated 6 months or over will not be accepted!

Please note that the following may prelude 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________/__________ Left Eye ______/____ **Colour Vision**__________ **Field of Vision**_____

Urinalysis (Labetix): Sugar________________ Protein______________ Blood____________________________

Concerns Past or Present	Yes	No	Comment
Eye or ear impairment, infections or injuries			
Rheumatic fever, TB, pleurisy or asthma. (a chest X-ray is required only if there is a family history of TB).			
Kidney or urine disorder, one kidney			
Diabetes mellitus			
Indigestion, vomiting, abdominal cramps			
Nervous breakdown, head injury, fits			
Acute Infections			
Fractures, dislocations, severe sprains			
Epilepsy, of application or in family			
Ears(state of T.M.S. and degree of deafness)			
Teeth – any braces			
Is there any abnormality in chest, heart , BP or C.N.S.			
Is there a hernia, undescended testis, organomegaly, cryptorchidism			
Have there been any medical suspensions from Boxing			

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

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

I ________________________________ certify that ________________________________
(Licensed Medical Physician (MD) Name) (Athletes Name)
IS FIT ☐ ***/ IS NOT FIT*** ☐ *to engage in Boxing.*
(please check one)

Physicians Signature________________ **CPSO License #**______________**Date Medical Conducted**____/_____/_____
Day Month Year

Address: ________________________________ **Telephone Number**____________ **Fax Number**______________

Boxing Ontario Applicant Signature____________________________________ Date ______________________
(Parental/Guardian signature if applicant is age 17 and under)

DK 9/12