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____Postal Code_____

Telephone Number_____Email Address_____Club_____

Please note that medical forms submitted to Boxing Ontario 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** ____/____/____/
Day Month Year

Address:_____**Telephone Number**_____**Fax Number**_____

Boxing Ontario Applicant Signature_____Date _____
(Parental/Guardian signature if applicant is age 17 and under)