USA Boxing Annual Medical Examination Certificate

Athlete Name: Last:______________________ First: _____________ DOB:__________ Date of Exam:__________

Examining Physician: If any of these boxes are marked "Yes", please go to page 3 of three.

GENERAL		
Acute and Chronic Infection:	Yes	No
Fever, chest infection; untreated Tuberculosis	Yes	No
Any implantable device which can alter physiologic processes or enhance performance	Yes	No

VISION		
Refractive (Lasik) and or intraocular surgery, cataract, retinal detachment	Yes	No
Recorded visual acuity in one or both eyes: Uncorrected, worse than 20/200	Yes	No
Corrected, worse than 20/60	Yes	No
Myopia of more than 3.50 diopter in one or both eyes	Yes	No

PULMONARY		
Severe COPD or uncontrolled Asthma	Yes	No
Pulmonary HTN	Yes	No
Severe aortic or pulmonary valve stenosis	Yes	No

CARDIOLOGY		
Current Myocarditis or Pericarditis	Yes	No
3rd degree heart block	Yes	No
Atrial or ventricular tachycardia	Yes	No
Coarctation of the aorta or aortic aneurysm	Yes	No
Unclosed significant patent ductus arteriosus	Yes	No
Ablation or surgical correction procedures that will require medical clearance and release by a cardiothoracic surgeon to return to combat sports	Yes	No
Resting blood pressure greater than 140/90 with history poor control in the recent past	Yes	No

Hematology		
Sickle Cell Disease	Yes	No
Severe blood dyscrasias and/or clotting disorders	Yes	No
Ongoing therapeutic anti-coagulation	Yes	No
Mononucleosis within the past month	Yes	No
Embolic disease within the past 6 months	Yes	No

Gastrointestinal		
Intestinal infection or fluid malabsorption syndrome	Yes	No

Endocrine		
Uncontrolled diabetes or uncontrolled thyroid disease	Yes	No

Immunity		
History of Hepatitis B, Hepatitis C or HIV infection	Yes	No

Skin		
Open infected lesions	Yes	No
Herpes Simplex, MRSA, Impetigo, untreated fungal infection	Yes	No

Neurological		
Any seizure activity within the last 3 years	Yes	No
Unresolved post-concussion symptoms. Stoppage of any athletic event or diagnosis of concussion within the past 2 weeks. Athlete will need medical clearance	Yes	No

Musculoskeletal		
Spinal Fractures, spondylosis, atlantoaxial instability, and the following conditions if they inhibit the boxers defense, balance or ability to use the authorized headgear/gloves: Loss of thumb or great toe, unstable subluxing joints	Yes	No

Family Medical History: (Additional Space is available on page 3 of 3)

Mother:____

Father:____

Sister:____

Brother:____

General Review of Systems: (If the answer is Yes to any question, please explain on page three (3) EXCEPT for question 16)

Question		
1. Have you ever had any surgeries?	YES	NO
2. Have you ever had any stays in a hospital longer than 24 hours?	YES	NO
3. Is a doctor currently treating you for anything?	YES	NO
4. Have you ever been unconscious or had a concussion? If "Yes" were you suspended for any period of time?	YES	NO
5. Have you been hit hard in the head in the last 6 weeks? NOT LIMITED TO SPORT	YES	NO
6. Have you had any of the following symptoms over the past two weeks: persistent headaches, ringing in the ears or blurry vision.	YES	NO
7. Does any significant disease run in your family like Marfans Syndrome or Sudden Cardiac Death?	YES	NO
8. Are you taking any medication?	YES	NO
9. Do you have any significant hearing loss?	YES	NO
10. Do you have or ever had a hernia?	YES	NO
11. Do you wear braces or a retainer?	YES	NO
12. Do you have breast implants?	YES	NO
13. Have you had or are you undergoing a sex reassignment?	YES	NO
14. Do you use any emergency lung inhaler to treat Asthma (like Albuterol)?	YES	NO
15. Do you use any type of insulin to treat Diabetes?	YES	NO
16. For Males: Do you have both testicles?	YES	NO
17. Have you had episodes of chest pain or heart palpitations?	YES	NO

PHYSICAL EXAMINATION

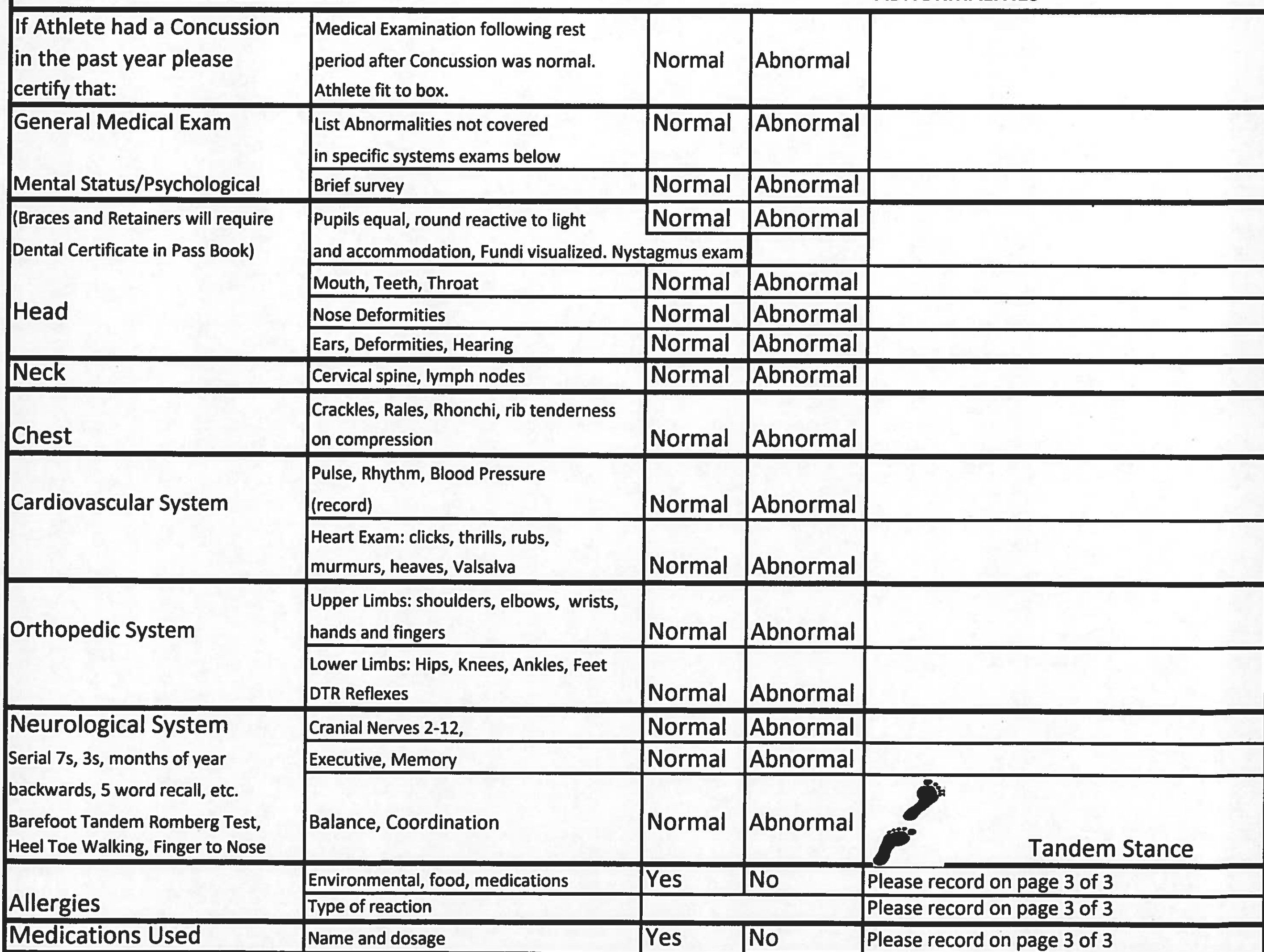
Male ____, Female____, Trans-Gender____

Height:_________Weight:_______lbs./Kg Temperature: ____Degrees Fahrenheit Visual Acuity:

Blood Pressure:_____/______(BP should be 140/90 or lower) Right Eye: Corrected:____/____, Uncorrected:____/____

Heart Rate:______BPM, Respirations:_______BPM (Vision Limits: 20/200 Uncorrected 20/60 Corrected)

Left Eye: Corrected:____/____, Uncorrected:____/____



MEDICAL CERTIFICATE				ABNORMALITIES
If Athlete had a Concussion in the past year please certify that:	Medical Examination following rest period after Concussion was normal. Athlete fit to box.	Normal	Abnormal	
General Medical Exam	List Abnormalities not covered in specific systems exams below	Normal	Abnormal	
Mental Status/Psychological	Brief survey	Normal	Abnormal	
(Braces and Retainers will require Dental Certificate in Pass Book)	Pupils equal, round reactive to light and accommodation, Fundi visualized. Nystagmus exam	Normal	Abnormal	
Head	Mouth, Teeth, Throat	Normal	Abnormal	
	Nose Deformities	Normal	Abnormal	
	Ears, Deformities, Hearing	Normal	Abnormal	
Neck	Cervical spine, lymph nodes	Normal	Abnormal	
Chest	Crackles, Rales, Rhonchi, rib tenderness on compression	Normal	Abnormal	
Cardiovascular System	Pulse, Rhythm, Blood Pressure (record)	Normal	Abnormal	
	Heart Exam: clicks, thrills, rubs, murmurs, heaves, Valsalva	Normal	Abnormal	
Orthopedic System	Upper Limbs: shoulders, elbows, wrists, hands and fingers	Normal	Abnormal	
	Lower Limbs: Hips, Knees, Ankles, Feet DTR Reflexes	Normal	Abnormal	
Neurological System	Cranial Nerves 2-12,	Normal	Abnormal	
Serial 7s, 3s, months of year backwards, 5 word recall, etc.	Executive, Memory	Normal	Abnormal	
Barefoot Tandem Romberg Test, Heel Toe Walking, Finger to Nose	Balance, Coordination	Normal	Abnormal	Tandem Stance
Allergies	Environmental, food, medications	Yes	No	Please record on page 3 of 3
	Type of reaction			Please record on page 3 of 3
Medications Used	Name and dosage	Yes	No	Please record on page 3 of 3

Any TUE (Therapeutic Use Exemption) Submitted: | Yes | No | If Yes, please explain on Page 3

Examining Physician: Questions answered "Yes" on page one are disqualifying conditions. Please record explanations to these questions on page 3 of 3.

Please provide brief explanation of questions marked "Yes" in Review of Systems page except for question #16. Please include system or question number. Significant Family Hx can also be recorded here.

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Examining Physician: Please use this space to record Medications:

Name:____________ Dosage:________ Frequency:__________ Name:________ Dosage:________ Frequency:________

Name:____________ Dosage:________ Frequency:__________ Name:________ Dosage:________ Frequency:________

Examining Physician: Please use this space to record ANY allergy including environmental, food and medicine and the reaction to each allergen:

Allergen:____________ Reaction:____________ Allergen:____________ Reaction:____________

Allergen:____________ Reaction:____________ Allergen:____________ Reaction:____________

Examining Physician: Please use the space below for any additional comment, concerns or questions:

____

____

Athlete Name:____________________ Date of Birth:____________

I hereby certify that I have answered all questions about my current and past medical history truthfully and I do not hold any person accountable for decisions to allow me to participate based on misinformation given during this exam.

Athlete Signature: **Date**

Athlete Guardian Signature (if athlete younger than 18 years of age at time of signing)

Athlete Guardian Signature: **Date**

Physician Printed name:__________________________ D.O./M.D.

Office Street Address: ________________________ City____________ State__________ Zip________

Phone Number______________ Fax Number_____________ Email:____________________

I recommend that this athlete be allowed to participate without any reservation. Yes____ No____

If the answer is "Yes", please check "Fit To Box" on Medical Certificate below. If the answer is "No", please explain briefly.

I recommend that this athlete be allowed to participate After the following issues are resolved:____________________

____

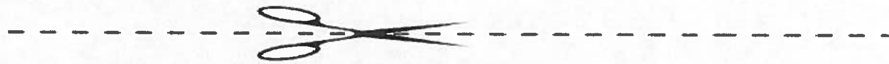
This athlete is "Not Fit To Box" for the following Disqualifying medical Reason(s)____________________________

______________________________________ (Please Check "Not Fit To Box" below on Medical Certificate)

Examining Physician Signature: **Date**

Detach at the dotted line below and keep the "Fit to Box" portion in the Athlete Pass Book.

LBC, retain upper portion of this document with the athlete records.



USA BOXING MEDICAL CERTIFICATE

Athlete		**Medical Doctor**	
Date of Birth:		Address:	
Signature:	Date:	Signature:	Date:

FIT TO BOX ☐

<u>NOT</u> FIT TO BOX ☐