



Northern California

USA Boxing, Inc.

**BOXING PHYSICAL FORM**

Name	Address	D.O.B.	Age
City	State	Zip Code	Phone

**HISTORY**

**HAS APPLICANT EVER HAD ANY OF THE FOLLOWING:**

SWOLLEN JOINTS	YES___ NO___	RHEUMATISM	YES___ NO___
FREQUENT HEADACHES	YES___ NO___	CHRONIC COUGH	YES___ NO___
SPITTING UP BLOOD	YES___ NO___	CONVULSIONS	YES___ NO___
SHORTNESS OF BREATH	YES___ NO___	FAINING SPELLS	YES___ NO___
VENEREAL DISEASE	YES___ NO___	DIZZY SPELLS	YES___ NO___
WORN OR WEAR GLASSES/CONTACT LENSES	YES___ NO___	BLURRING VISION	YES___ NO___
DIABETIC	YES___ NO___	EPILEPSY	YES___ NO___
DEBILITATING DISEASE	YES___ NO___	ORAL SURGERY	YES___ NO___

Explain any "YES" answers: \_\_\_\_\_

HAS APPLICANT EVER BEEN KNOCKED UNCONSCIOUS IN ANY SPORT: YES\_\_\_ NO\_\_\_

IF "YES," LONGEST DURATION OF UNCONSCIOUSNESS: \_\_\_\_\_

ALSO PLEASE GIVE DATE AND PARTICULARS: \_\_\_\_\_

**MILITARY SERVICE**

MILITARY SERVICE: YES\_\_\_ NO\_\_\_ TYPE OF DISCHARGE: \_\_\_\_\_

IF REJECTED, PLEASE GIVE REASON: \_\_\_\_\_

ANY HISTORY OF MENTAL ILLNESS? YES\_\_\_ NO\_\_\_

IF YES, EXPLAIN IN FULL: \_\_\_\_\_

ALLERGIC REACTIONS TO ANY MEDICATION: YES\_\_\_ NO\_\_\_

EXPLAIN: \_\_\_\_\_

TAKING MEDICATION REGULARLY? YES\_\_\_ NO\_\_\_

EXPLAIN: \_\_\_\_\_

**EXAMINATION**

GENERAL APPEARANCE: \_\_\_\_\_

HT. \_\_\_\_\_ WT. \_\_\_\_\_ TEMP. \_\_\_\_\_ AGE \_\_\_\_\_ PULSE (AT REST) \_\_\_\_\_ BP (AT REST) \_\_\_\_\_

DISABLING SCARS: \_\_\_\_\_

EYES: VISION WITHOUT GLASSES RIGHT \_\_\_\_\_ / \_\_\_\_\_ LEFT \_\_\_\_\_ / \_\_\_\_\_

PUPILS EQUAL YES\_\_\_ NO\_\_\_ REACT TO LIGHT YES\_\_\_ NO\_\_\_

EARS – AUDITORY CANALS CLEAR YES\_\_\_ NO\_\_\_ TYMPANIC MEMBRANES NORMAL YES\_\_\_ NO\_\_\_

MOUTH \_\_\_\_\_ TEETH \_\_\_\_\_ TONSILS \_\_\_\_\_ NECK \_\_\_\_\_

ENLARGED GLANDS YES\_\_\_ NO\_\_\_ GOITER \_\_\_\_\_ YES\_\_\_ NO\_\_\_

HEART: PULSE RHYTHM REGULAR \_\_\_\_\_ IRREGULAR \_\_\_\_\_

APICAL IMPULSE HEAVING \_\_\_\_\_ NORMAL \_\_\_\_\_

ENLARGEMENT YES\_\_\_ NO\_\_\_ MURMURS YES\_\_\_ NO\_\_\_

LUNGS CLEAR YES\_\_\_ NO\_\_\_ RALES YES\_\_\_ NO\_\_\_

ABDOMEN: ENLARGEMENT OF LIVER YES \_\_\_\_\_ NO \_\_\_\_\_

ENLARGEMENT OF SPLEEN YES \_\_\_\_\_ NO \_\_\_\_\_

HERNIA \_\_\_\_\_ FEMORAL \_\_\_\_\_ INGUINAL \_\_\_\_\_ VENTRAL \_\_\_\_\_

GENITALIA : DISCHARGE YES\_\_\_ NO\_\_\_

HANDS: RECENT INJURY YES\_\_\_ NO\_\_\_ FRACTURES: YES\_\_\_ NO\_\_\_

HANDS: SWELLING YES\_\_\_ NO\_\_\_ UNHEALED WOUNDS YES\_\_\_ NO\_\_\_

REFLEXES: PUPILS \_\_\_\_\_ KNEE JERKS: \_\_\_\_\_ ROMBERG: \_\_\_\_\_ BABINSKIE \_\_\_\_\_

SKIN: RASH \_\_\_\_\_ BOILS \_\_\_\_\_ ANY OTHER \_\_\_\_\_

REMARKS: \_\_\_\_\_

I HAVE THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_, EXAMINED THE ABOVE NAMED APPLICANT, FINDING HIM/HER OF SATISFACTORY/UNSATISFACTORY PHYSICAL CONDITION TO BE CERTIFIED AS AN AMATEUR BOXER.

I certify under penalty of perjury that the foregoing history is true and correct; further, I realize that any misstatement in said history will result in revocation or rejection of USA/BOXING passbook.

NOTE: It is the responsibility of the boxer to inform his/her coach and the ringside doctor (pre-bout physical) of any physical conditions(s) or problems which could affect the performance or well-being of the boxer or his/her opponents.

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY AND STATE

SIGNATURE: \_\_\_\_\_

\_\_\_\_\_  
PARENT OR LEGAL GUARDIAN (IF UNDER 18 YEARS OF AGE)