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___	FAINTING 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.

_____
PHYSICIAN'S SIGNATURE

_____
ADDRESS

_____
CITY AND STATE

***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.**

SIGNATURE:_____

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