



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

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.

ADDRESS

CITY AND STATE

SIGNATURE: _____

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