USA Boxing, Inc.

PRE-BOUT PHYSICAL EXAMINATION FORM

A promoter of amateur boxing shall file this physical examination form of a contestant with the LBC Registration Chairman not later than 24 hours after termination of a sanctioned boxing event.

PRINT CLEARLY – DO NOT FOLD OR WRINKLE

Last Name: _____ First Name: _____ Date: ____/____/____

Club Affiliation: _____ Coach's Name _____

Please check one. Male ☐ Female ☐ Age: _____ Date of Birth: ____/____/____

All questions are to be answered as truthfully and as accurately as possible.
If you do not fully understand any question(s), notify the doctor in attendance.

If you are under the age of 18, do you have approval/permission from your parent or guardian to enter and compete in this boxing contest? Yes ☐ No ☐

All Contestants – Select Answer

1.	Has a doctor ever told you not to participate in any athletic activity?	Yes ☐	No ☐
2.	Is a doctor currently treating you for anything?	Yes ☐	No ☐
3.	Have you ever been rendered unconscious or had a concussion in boxing or any other activity?	Yes ☐	No ☐
4.	Have you been hit hard in the head in the past six (6) weeks?	Yes ☐	No ☐
5.	Have you had any headaches in the past two weeks?	Yes ☐	No ☐
6.	Do you have a history of Hepatitis B, Hepatitis C or HIV infection?	Yes ☐	No ☐
7.	Do you have any exposed open infected skin lesions?	Yes ☐	No ☐

Contestant's Signature: _____ Date: ____/____/____

**********************Take This Completed Form To Your Physical Examination**********************

PHYSICAL EXAMINATION Blood Pressure ____/____ Pulse _____ Fit? Yes ☐ No ☐

If No, please list reasons and comments: _____

_____

Name of attending physician (Print Clearly) _____ MD ☐ DO ☐

Physician's Signature: _____ Date: ____/____/____

Questions for the Boxer

Boxer Name: _____ Age: _____ Weight: _____

When was your last bout?: _____ When did you last spar? _____

Have you **ever** been knocked out (lost consciousness) in a bout or sparring session? Yes ☐ No ☐

Have you **ever** passed out during/after exercise in any sport? Yes ☐ No ☐

Have you experienced any of the following in the past thirty (30) days?

Headaches or Dizziness Yes ☐ No ☐
Nausea or Vomiting Yes ☐ No ☐
Double vision or blurred vision Yes ☐ No ☐
Inability to concentrate Yes ☐ No ☐
Nose bleed Yes ☐ No ☐
Do you feel well enough to box today? Yes ☐ No ☐
Do you take medication? Yes ☐ No ☐
If yes, are you supposed to take medication? Yes ☐ No ☐
If yes, please list your medications:

Please explain any "yes" answers above, and any questions or concerns you would like to discuss further with the ringside physician:

Boxer's Signature: _____ Date: ____/____/____

Note: This form is only to be filled out by the boxer named above.