Pre Bout Medical Check

BERMUDA BOXING FEDERATION

IBA INTERNATIONAL BOXING ASSOCIATION

Boxer

Full Name:		□ Male □ Female
Contact #:	DOB:	Age:
If Boxer under 18 years of age they will require Parent / Guardian details and Parent / Guardian signature implies consent to participate:		
Parent/Guardian Full Name:		
Contact No:	Address:	

ANSWER QUESTIONS		**Circle Answer**	
-	Have you ever been admitted to Hospital?	Yes	No
-	Have you had medical treatment for anything in the last 3 months?	Yes	No
Have you suffered from any of the following?			
-	Any eye disorders or operations (including laser eye surgery)?	Yes	No
-	Any broken bones or cuts needing treatment in the previous 6 months?	Yes	No
-	Epilepsy or any other type of fit, faint, convulsion or black-out?	Yes	No
How are you leading into this event?			
-	Are you taking any medication now?	Yes	No
-	After your last bout, were you medically suspended for any reason?	Yes	No
-	Do you presently have a cough, cold or runny nose?	Yes	No
-	Have you been unwell in the last month?	Yes	No
-	When did you last box? Date:		
-	Were you injured at that time?	Yes	No
-	Do you understand the sport-specific medical risks of boxing?	Yes	No
-	Woman Only - can you confirm you are **not** pregnant?	Yes	No

Boxer's Signature:	Date:
If under 18 years old, Parent/Guardian's consent to Participate - Signature:	Date:

DOCTOR'S EXAMINATION NOTES	General:	
Hands:		
Ear Nose Throat (including gum shield fit etc):	Eyes:	
CONFIRMED FIT TO BOX:	☐ YES	☐ NO
Doctor's Signature:	Doctor's Name:	
Date:		