

**CHOWCHILLA PAL
PHYSICAL EXAMINATION FORM**

GENERAL APPEARANCE:

Ht____ Wt____ %Body fat____ Temp____ Pulse (at rest)____ BP (at rest)____ Resp____

HEAD:

- Eyes: Vision w/o glasses R___/___ L___/___ Pupils equal y___ n___ Reactive to light y___ n___
- Ears: Canals n___ a___ TM's n___ a___
- Nose: Mucous membranes n___ a___ Nasal Bones n___ a___
- Throat/Neck: Teeth n___ a___ Tonsils n___ a___ Tongue n___ a___ Glands n___ a___ Goiter n___ a___

CHEST:

Heart sounds n___ a___ Apical Impulse n___ a___ Murmur n___ a___ Rhythm n___ a___
Lung sounds n___ a___ Expansion n___ a___ Rales n___ a___ Wheezes n___ a___

ABDOMEN:

Surgical Scarring n___ a___ Liver span n___ a___ Spleen n___ a___ Bowel sounds n___ a___ Hernias n___ a___
If hernia present, type_____

GENITALIA:

Male: Testicles n___ a___ Scrotum n___ a___ Discharges n___ a___ Varicocele n___ a___

EXTREMITIES:

Hands: recent injury n___ a___ Swelling n___ a___ Fractures n___ a___ Open skin n___ a___
Reflexes: Elbow n___ a___ Knee n___ a___ Romberg n___ a___ Babinski n___ a___

SKIN:

Identifiable or disabling scars_____

Rash n___ a___ Boils n___ a___ Broken skin n___ a___

ADDITIONAL COMMENTS:_____

I, _____ have this _____ day of _____, 20____, examined the above named applicant and find him/her to be in satisfactory/unsatisfactory physical condition to be certified as a amateur boxer for Chowchilla P.A.L.. I certify under penalty of perjury that the foregoing evaluation of findings is true complete and correct.

Signature of treating medical provider: _____ (X)

Name _____
Address _____
City _____ State _____ ZIP _____

(stamp)

United States Amateur Boxing
Central California Association, Inc.
Physical Examination Form

Name _____ Date of Birth _____ Age _____

Address _____ Telephone (Home) _____

Street or P.O. Box City State Zip

HISTORY

Has the applicant had or do they have any of the following conditions:

Swollen Joints	y__ n__	Rheumatism	y__ n__	Frequent Headaches	y__ n__
Convulsion	y__ n__	Diabetes	y__ n__	Chronic Cough	y__ n__
Glasses	y__ n__	Fainting spell	y__ n__	Spitting of Blood	y__ n__
Epilepsy	y__ n__	Dizzy spell	y__ n__	Shortness of Breath	y__ n__
Blurred Vision	y__ n__	Oral Surgery	y__ n__	Venereal Disease	y__ n__

Debilitating Disease y__ n__ Please explain if yes _____

Have you ever been knocked unconscious in any sport? y__ n__ Please explain if yes _____

Any History of Mental Disease? y__ n__ If yes, please explain _____

List all Medical Allergies or state "NONE" _____

List all Medications you are currently using including over-the-counter or State "NONE" _____

MILITARY SERVICE

Have you served in the Military or Reserve? y__ n__ Type of Discharge _____

If a Medical Discharge, please explain _____

If rejected, please explain _____

**DISCLOSURE STATEMENT
PLEASE READ BEFORE SIGNING**

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 ultimate responsibility of the boxer to inform his/her coach and the Ringside Physician of any physical condition(s) or problem(s) which could affect the performance or well being of himself/herself or the opponent(s).

Signature of boxer _____ Date _____

Signature of Parent or Guardian _____ Date _____

(For boxer under the age of 18 years old only)