

DECLARATION OF FIT TO BOX FORM

Country:

First Name:

Last Name:

Date Of Birth: / /	Age: Years	Mobile Number:	
ANSWER ALL QUESTIONS			
Have you ever been admitted t	Yes□	No□	
Have you had medical treatme	Yes□	No□	
Have you suffered from any o			
Any eye disorders or operation	Yes□	No□	
Any broken bones or cuts need	Yes□	No□	
Epilepsy or any other type of fi	Yes□	No□	
How are you today?			
Are you taking any medication	Yes□	No□	
Do you presently have a cough	Yes□	No□	
Have you been unwell in the la	Yes□	No□	
When did you last box?			
Were you injured at that time?	Yes□	No□	
After your last bout, were you	Yes□	No□	
Do you understand the sport-sp	No □	Yes□	
Do you wish to box today?	No □	Yes□	
WOMEN ONLY – can you cor	No □	Yes□	
Boxer's Signature:	Dated:		



DOCTOR'S EXAMINATION NOTES	General:
Hands:	
ENT (incl gum shield fit etc):	Eyes:
CONFIRMED FIT TO BOX: YES □ NO □	Date/Time of Medical
Doctor's Signature	Name:
Country:	IBA certified date:

Keep this form ringside for making contemporaneous notes of pre-, intra-, and post-bout medical aspects, to be transposed as and when appropriate. Space for making contemporaneous ringside notes during the bout and of the post-bout examination findings can be found below:

In-Bout Notes:				
Signed:	Dated:	Name:		
Post Bout Medical Notes:				
Signed:	Dated:	Name:		