

**IRISH AMATEUR BOXING ASSOCIATION MEDICAL EXAMINATION**  
(See overleaf)

Surname \_\_\_\_\_ Forename \_\_\_\_\_

Club \_\_\_\_\_ County \_\_\_\_\_ Date of Birth \_\_\_\_\_

FH/PMH \_\_\_\_\_

Height/Weight \_\_\_\_\_

CVS Pulse \_\_\_\_\_ B/P \_\_\_\_\_ Murmurs \_\_\_\_\_

Other \_\_\_\_\_

R.S. Chest Deformity \_\_\_\_\_ Lungs \_\_\_\_\_

L.S. Any Joint Deformities \_\_\_\_\_

Any History of Fractures(s) \_\_\_\_\_

ABDOMEN Hernia (Y/N) \_\_\_\_\_ Scars \_\_\_\_\_

Testes R \_\_\_\_\_ L \_\_\_\_\_

Central Nervous System \_\_\_\_\_

Eyes V/A \_\_\_\_\_ L \_\_\_\_\_ R \_\_\_\_\_ Fundi \_\_\_\_\_

Ears \_\_\_\_\_ Hearing \_\_\_\_\_

Urine Glucose \_\_\_\_\_ Protein \_\_\_\_\_ Haem \_\_\_\_\_

Signed \_\_\_\_\_ (Medical Officer) Date: \_\_\_\_\_

Doctor's Stamp

Based on medical examination conducted on \_\_\_\_\_ by \_\_\_\_\_  
a record card may / may not be issued.

Registration No. \_\_\_\_\_ Signed: \_\_\_\_\_  
I.A.B.A. Medical Commission

**INSTRUCTIONS TO DOCTOR**

1. The following conditions are among those rendering this person unfit to box:

- \* Epilepsy
- \* Diabetes
- \* Retinal Detachment
- \* History of Serious Head Trauma
- \* Acute Infections
- \* Haemorrhagic Diseases
- \* Valvular / Sepal defect of Heart
- \* Hypertension
- \* Hepato / Splenomegally
- \* Absence of Kidney
- \* V.A.: Eyes must be Tested Without Contact Lenses or Glasses by Snelling method.

Visual acuity must be at 6/18 in better & 6/36 in other.

2. If you have any problems please ring 01-4533371 or fax 01-4540777

**NOTICE TO BOXER**

1. Take this form with you when going to doctor.
2. Also bring with you a stamped envelope addressed to the **Medical Registrar of your Province**