

IBA

Registration & Medical Screening Form

www.internationalboxingalliance.co.uk



**The Locker Room Boxing Gym, Southend Central Railway Station, Clifftown
Road,
Southend On Sea, Essex SS1 1AB TEL: 01702 338402**

(please print clearly)

Part 1 –To be completed by athlete or parent/guardian if under legal age of 18

Name _____

DOB _____

Nationality _____

Address _____ Postcode _____

Email Address _____

Tel. _____

Weight _____ Height _____ Boxing Club _____

If the applicant has or had any of the following illnesses, give particulars below:

YES / NO

1. Eye or ear impairment, infections or injuries: _____
2. Rheumatic fever, T.B., pleurisy or asthma: _____
3. Kidney or urine disorder, one kidney: _____
4. Diabetes mellitus: _____
5. Indigestion, vomiting, abdominal cramps: _____
6. Nervous breakdown, head injury, fits: _____
7. Acute infections: _____
8. Fractures, dislocations, severe sprains: _____
9. Epilepsy of applicant or in family: _____
10. Any suspensions from boxing? _____

Date

Signature of Athlete

Signature of Parent / Guardian

Please include the following with your form

Passport photos x 4

Photo (JPEG)

Copy of birth certificate

Copy of Photo ID (i.e Passport, Drivivg License)

Annual Registration Fee - £25

Please make cheques payable to The Locker Room

**This form must be fully completed and all documents enclosed before
participating in any
International Boxing Alliance event**

Part II – To be completed by the Physician

Note: the following may preclude from boxing: (1) impaired vision – worse eye less than 20/120 and better eye less than 20/60; (2) squint; (3) recurrent chronic suppurative otitis media; (4) chest expansion less than 2"; (5) total deafness; (6) albuminuria; (7) hernia, organomegaly or undescended testis; (8) heart lesions.

WEIGHT _____ HEIGHT _____ EXPIRATION _____ INSPIRATION _____

VISION Right eye 20/_____ Left eye 20/_____
COLOUR VISION _____ FIELD OF VISION _____

EARS (state of T.M.S. and degree of deafness) _____

TEETH (any braces) _____

Is there any abnormality in chest, heart, B.P. or C.N.S.? _____

Is there a hernia, undescended testis, organomegaly, cryptorchidism? _____

Urinalysis (Labetix) Sugar _____ Protein _____ Blood _____

Chest X-ray required only if there is a family history of T.B. _____

Additional for the female boxer: Note: confirmed pregnancy disqualifies from boxing. Are there breast lesions, bleeding, masses, other dysfunction, pain? _____

Abnormality in menstrual pattern? Amenorrhea? _____

Lower pelvic pain? _____

IN MY OPINION AS THE MEDICAL OFFICER CONDUCTING THIS EXAMINATION THE APPLICANT NAMED ABOVE IS FIT TO ENGAGE AND COMPETE IN THE SPORT OF BOXING

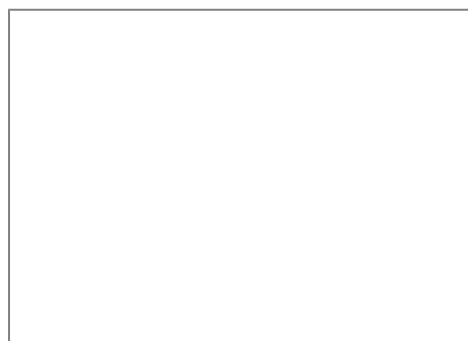
Name of Medical Officer _____

Address _____ Postcode _____

Telephone no. _____

Signature _____ Date _____

Medical Office Stamp



EYE EXAMINATION FORM

First Examination _____

Re-Eamination _____

NAME _____

DOB _____

REG NO _____

CLUB _____

ADDRESS _____

Eye examination form to be completed by an Ophthalmic Optician/Consultant

Visual Standards (Snellen's type figures without glasses please) _____

Visual Fields _____

Ocular Tension _____

Ocular Movements _____

Ophthalmospic examination (with special attention to retinal defects) _____

Date of Examination _____

I AM SATISFIED AS TO THE CORRECT IDENTITY OF THE EXAMINEE WHO HAS PRODUCED FOR ME HIS BOXER'S LICENSE OR PASSPORT, OR ALTERNATIVELY, I CONFIRM HIS/HER LIKENESS BY SIGNING BELOW AFTER SEEING THE ATTACHED PHOTOGRAPH.

Signature and stamp of Optician/Consultant _____

Address Stamp or Address _____

Attach here passport
photo or copy of
BBU License