

**COMMONWEALTH OF PENNSYLVANIA
STATE ATHLETIC COMMISSION**

PHYSICIAN'S EXAMINATION - DATE: _____

BOXER'S NAME: _____

SS #: _____ DATE OF BIRTH: _____

AGE: _____ Federal ID# _____ CURRENT WEIGHT: _____ HEIGHT _____

TO BE COMPLETED BY EXAMINING PHYSICIAN:

UNLESS STATED Indicate normal findings by placing a check (VISION must be at least **20/70-W/O Glasses**)

1. Visual Acuity: **List Actual** _____ Peripheral Vision (**DEGREES**) _____

2. Pupils: Regular _____ Equal _____ React to light _____ Anterior Segment _____

3. Periorbital Regions (describe scars, if any) _____

4. Oropharynx: _____ Ears (discharge, etc.) _____

5. Lungs: (Any abnormal breath sounds, friction rub, rales, etc.) _____

6. Heart Rate: **List Actual** _____ Any irregularity _____ Murmurs _____

7. Pulse Rate: **List Actual** _____ Blood Pressure: **List Actual** _____

8. Abdominal Exam: _____

9. Extremities (Stiffness, swelling, tenderness): **YES** ___ **NO** _____

10. Hands (fists): Any Fractures, or Swelling: **YES** ___ **NO** _____

11. Nervous System: Orientation _____ Cerebellum _____ Cranial Nerves _____

12. Nose: Instability **YES** ___ **NO** _____ Obstruction **YES** ___ **NO** _____

13. Coordination: Finger to Nose - Normal _____ Abnormal _____

14. Tandem Gait: Normal _____ Abnormal _____

15. **In you opinion is this individual in condition to compete as a professional Boxer: YES** ___ **NO** ___

IF NO WHY _____

NAME OF EXAMINING PHYSICIAN (PRINT): _____

TELEPHONE #: _____ **FAX #:** _____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

SEND TO:

PENNSYLVANIA STATE ATHLETIC COMMISSION
2601 North 3rd Street
HARRISBURG, PA 17110

TELEPHONE #: 717-787-5720
FAX #: 717-783-0824