

APPENDIX C - Medical Certificate Template

Athlete

<b>NAME:</b>	_____
<b>DATE OF BIRTH:</b>	_____
<b>SIGNATURE:</b>	_____ <b>DATE:</b> _____

Doctor

<b>NAME:</b>	_____
<b>TITLE/POSITION:</b>	_____
<b>ADDRESS:</b>	_____
<b>SIGNATURE:</b>	_____ <b>DATE:</b> _____
<b>STAMP</b>	_____
<b>COMMENTS:</b>	_____

Fit to Box

Not Fit to Box

**QUESTION FOR ATHLETE: IF YES, EXPLAIN**

1. Is a Doctor currently treating you for anything?

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2. Have you ever been unconscious or had a concussion?

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3. Have you been hit hard in the head in the last 6 weeks?

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4. Have you had any headache in the last 2 weeks?

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5. Do you have any problem with bleeding?

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6. Do you have a history of hepatitis B or hepatitis C or HIV infection?

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7. Does any disease run in your family? Sudden unexpected deaths?

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8. Have you had any surgery?

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9. Have you ever had to stay in a hospital?

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10. Do you have any medical condition?

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MEDICAL CERTIFICATE		ABNORMALITIES		
<b>If Athlete had a Concussion in the past year, please certify that:</b>	Medical Examination following rest period after Concussion was normal Athlete Fit To Box	Normal	Abnormal	
<b>General Medical Exam</b>	List abnormalities not covered in specific system exams below:			
<b>Mental Status/ Psychological</b>	Brief survey	Normal	Abnormal	
<b>Head</b>	Cranial nerves, eyes, pupil size and reactivity, Fundi, vision by chart (record)	Normal	Abnormal	
	Mouth, teeth, throat	Normal	Abnormal	
	Ears	Normal	Abnormal	
	Temporomandibular joint	Normal	Abnormal	
<b>Neck</b>	Cervical spine, lymph nodes	Normal	Abnormal	
<b>Chest</b>	Breath sounds, rib tenderness on compression	Normal	Abnormal	
<b>Cardio Vascular System</b>	Pulse/blood pressure (record)	Normal	Abnormal	
	Heart examination: sounds, murmurs, heaves, size, rhythm	Normal	Abnormal	
<b>Orthopedic System</b>	Upper limb: shoulder, wrist, hand, fingers	Normal	Abnormal	
	Lower limb: foot, ankle, knee, hip	Normal	Abnormal	
<b>Neurological System</b>	Reflexes	Normal	Abnormal	
	Verbal Responses	Normal	Abnormal	
	Motor responses and balance	Normal	Abnormal	
<b>Allergies</b>	(record)	Yes	No	
	Type of reaction (record)			
<b>Medications used</b>	Name and dosage (record)	Yes	No	

Any TUE Submitted ?  No  Yes (If YES, please explain)

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