



MANDATORY BOXER PARTICIPATION FORM

I. BOXER INFORMATION

BOXER NAME (Last Name, First Name):

BOXER DATE OF BIRTH (Month/Day/Year):

ADDRESS WHERE BOXER LIVES:

BOXER CELL PHONE NUMBER:

BOXER EMAIL ADDRESS:

WHAT SCHOOL DOES BOXER CURRENTLY ATTEND?

II. PARENT/GUARDIAN EMERGENCY CONTACT INFORMATION

Must provide name and contact information for at least one parent or guardian who we can contact if there is an emergency

NAME OF PARENT/GUARDIAN #1:

CELL PHONE NUMBER OF PARENT/GUARDIAN #1:

ADDRESS OF PARENT/GUARDIAN #1:

EMAIL ADDRESS OF PARENT/GUARDIAN #1:

NAME OF PARENT/GUARDIAN #2:

CELL PHONE NUMBER OF PARENT/GUARDIAN #2:

ADDRESS OF PARENT/GUARDIAN #2:

EMAIL ADDRESS OF PARENT/GUARDIAN #2:

III. MEDICAL INFORMATION

DATE OF BOXER'S MOST RECENT PHYSICAL:

IV. PERMISSION, CONSENT, WAIVER AND RELEASE

My name is _____ and I am the [PARENT] / [LEGAL GUARDIAN] of a [MALE] / [FEMALE] named _____ who is applying to participate in the boxing program at CINCINNATI GOLDEN GLOVES FOR YOUTH. By signing below, I am indicating that I consent to my child's participation in the boxing program and other activities at CINCINNATI GOLDEN GLOVES FOR YOUTH, and I am further certifying that:

1. I HAVE READ AND I UNDERSTAND THIS PERMISSION, CONSENT, WAIVER AND RELEASE.
2. I am the custodial parent or legal guardian of the child applying to participate in the CGGY boxing program.

3. My child is fit to participate in the sport of boxing and is in good health and proper physical condition for all boxing-related activities, including, but not limited to, training, running, aerobics, calisthenics, weightlifting, sparring, and participating in competitions.
4. I consent to my child participating in the sport of boxing and all boxing-related activities, including, but not limited to, training, running, aerobics, calisthenics, weightlifting, sparring, and participating in competitions.
5. In consideration of my child's participation I consent to the terms of this PERMISSION, CONSENT, WAIVER AND RELEASE, and I agree that the Terms set forth herein shall be binding on me, my child, and our heirs, legal representatives, agents, successors and assignees.
6. I FULLY UNDERSTAND THAT:

- (a) OLYMPIC STYLE AMATEUR BOXING INVOLVES RISKS AND DANGERS OF SERIOUS BODILY INJURY, INCLUDING SICKNESS, DISEASE, PERMANENT OR TEMPORARY DISABILITY, PARALYSIS AND DEATH, and these risks may be caused by the action or inaction of participants, coaches, volunteers, or by equipment or conditions at CGGY's facilities, or by negligence ("the Risks"); and
- (b) there may be other risks, including loss or injury, that are not necessarily inherent in boxing and are not readily foreseeable ("Other Risks"); and
- (c) I FULLY ACCEPT AND ASSUME RESPONSIBILITY FOR ALL THE RISKS, INCLUDING OTHER RISKS, AND FOR ANY LOSSES, CLAIMS, DAMAGES, INJURIES, OR COSTS INCURRED BY ME OR MY CHILD AS A RESULT OF MY CHILD'S PARTICIPATION IN CGGY'S ACTIVITIES AND PROGRAMS.

7. I HEREBY RELEASE, DISCHARGE, COVENANT NOT TO SUE, AND AGREE TO DEFEND, INDEMNIFY AND HOLD HARMLESS Cincinnati Golden Gloves for Youth, the Cincinnati Recreation Commission, LaRosa's Inc., USA Boxing, the Ohio Local Boxing Committee ("LBC"), and each of their respective employees, administrators, directors, officers, agents, owners, shareholders, successors, assignees, advertisers, and sponsors, along with other participants, and the owners or lessors of the premises on which the activities take place ("The Released Parties") FROM ALL LIABILITY, CLAIMS, DEMANDS, LOSSES, INJURIES, OR DAMAGES CAUSED IN WHOLE OR IN PART BY ANY OR ALL OF THE RELEASED PARTIES, INCLUDING NEGLIGENCE AND/OR NEGLIGENT RESCUE OPERATIONS.

8. IN THE EVENT THAT ANYONE ATTEMPTS TO MAKE ANY CLAIMS AGAINST THE RELEASED PARTIES ARISING FROM MY CHILD'S PARTICIPATION IN CGGY'S PROGRAMS AND ACTIVITIES, I FURTHER AGREE TO INDEMNIFY, SAVE AND HOLD HARMLESS THE RELEASED PARTIES FROM ANY LITIGATION EXPENSES, ATTORNEYS FEES, AND LIABILITY FOR DAMAGES, COSTS AND LOSSES THAT MAY BE INCURRED AS A RESULT.

9. I COVENANT NOT TO SUE OR ALLEGE CLAIMS AGAINST ANY OF THE RELEASED PARTIES, EITHER ON MY BEHALF OR ON BEHALF OF MY CHILD, IN CONNECTION WITH ANY CLAIMED LOSS, INJURY OR DAMAGE ARISING FROM MY CHILD'S PARTICIPATION IN CGGY'S PROGRAMS OR ACTIVITIES.

Parent/Guardian Signature: _____ Date: _____

V. AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As the [PARENT] / [LEGAL GUARDIAN] of _____, I hereby authorize and give my full consent for my child to receive medical, surgical, or dental treatment in the event of an emergency. In the event of any such emergency, I authorize Cincinnati Golden Gloves for Youth to act on my behalf if a medical or dental emergency arises while my child is participating in CGGY's activities and programs. I further understand that I am responsible for any and all costs associated with my child receiving any such emergency medical, surgical, or dental treatment.

Parent/Guardian Signature: _____ Date: _____

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____
 Name _____ Date of birth _____
 Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.
 Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

| GENERAL QUESTIONS | Yes | No |
|---|-----|----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | | |
| 2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____ | | |
| 3. Have you ever spent the night in the hospital? | | |
| 4. Have you ever had surgery? | | |
| HEART HEALTH QUESTIONS ABOUT YOU | Yes | No |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____ | | |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) | | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| 11. Have you ever had an unexplained seizure? | | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | | |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY | Yes | No |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? | | |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | |
| BONE AND JOINT QUESTIONS | Yes | No |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | |
| 20. Have you ever had a stress fracture? | | |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | | |
| 22. Do you regularly use a brace, orthotics, or other assistive device? | | |
| 23. Do you have a bone, muscle, or joint injury that bothers you? | | |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | |

| MEDICAL QUESTIONS | Yes | No |
|---|-----|----|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 28. Is there anyone in your family who has asthma? | | |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 33. Have you had a herpes or MRSA skin infection? | | |
| 34. Have you ever had a head injury or concussion? | | |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 36. Do you have a history of seizure disorder? | | |
| 37. Do you have headaches with exercise? | | |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 40. Have you ever become ill while exercising in the heat? | | |
| 41. Do you get frequent muscle cramps when exercising? | | |
| 42. Do you or someone in your family have sickle cell trait or disease? | | |
| 43. Have you had any problems with your eyes or vision? | | |
| 44. Have you had any eye injuries? | | |
| 45. Do you wear glasses or contact lenses? | | |
| 46. Do you wear protective eyewear, such as goggles or a face shield? | | |
| 47. Do you worry about your weight? | | |
| 48. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 49. Are you on a special diet or do you avoid certain types of foods? | | |
| 50. Have you ever had an eating disorder? | | |
| 51. Do you have any concerns that you would like to discuss with a doctor? | | |
| FEMALES ONLY | | |
| 52. Have you ever had a menstrual period? | | |
| 53. How old were you when you had your first menstrual period? | | |
| 54. How many periods have you had in the last 12 months? | | |

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

| EXAMINATION | | | |
|---|--------|---|---|
| Height | Weight | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| BP / (/) | Pulse | Vision R 20/ | L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N |
| MEDICAL | NORMAL | ABNORMAL FINDINGS | |
| Appearance <ul style="list-style-type: none"> Marian stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | | |
| Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing | | | |
| Lymph nodes | | | |
| Heart* <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) | | | |
| Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitourinary (males only)* | | | |
| Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis | | | |
| Neurologic† | | | |
| MUSCULOSKELETAL | | | |
| Neck | | | |
| Back | | | |
| Shoulder/arm | | | |
| Elbow/forearm | | | |
| Wrist/hand/fingers | | | |
| Hip/thigh | | | |
| Knee | | | |
| Leg/ankle | | | |
| Foot/toes | | | |
| Functional <ul style="list-style-type: none"> Duck-walk, single leg hop | | | |

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

†Consider GU exam if in private setting. Having third party present is recommended.

‡Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO



Physical Examination Signature Page

Attach this page to your athlete passbook, and keep a copy for your records

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Boxer's name: _____ Date of Birth: _____

Boxer's signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____

_____ Cleared for all sports without restriction

_____ Cleared for all sports without restriction with recommendations for further evaluation for _____

_____ Not cleared

_____ Pending further evaluation

_____ For any sports

_____ For certain sports _____

Reason: _____

Recommendations: _____

I have examined the above-named athlete and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete and parent/guardian.

Name of Physician/P.A./or Nurse Practitioner: _____

Address: _____ Phone: _____

Signature: _____ Date: _____