

Boxing BC Association Restrictions Affidavit*Please type or Print Legibly*

Athlete's Name _____ Boxing Canada Reg. # _____

Please be advised that _____ is restricted from competing
(Name of Boxer)in competitive boxing or sparring for _____ days. This restriction period begins on
(30 – 60 – 90)_____ and ends on _____.
Date DateThis Restriction is due to _____ rendered while said boxer was competing
(KO – TKO)against _____ at the _____
Name of Opponent Name of Eventon _____.
Date

Holder of Sanction	Signature	Date
Physician	Signature	Date
Referee	Signature	Date

We the undersigned have read and understand both the above and reverse side information regarding the restriction period and agree to fully comply.

Boxer	Signature	Date
Boxer's Coach	Signature	Date

Upon completion of the above restriction period, the boxer must have the medical release form on the reverse completed by his/ her physician/ He/ she must immediately forward a copy to his/ her Provincial Office before returning to competitive boxing or sparring. Failure to do so may result in disciplinary action from your Provincial Association.

The Sanction Holder must immediately forward copies to the Provincial Office, the President or his designate who, upon receipt, shall forward copies to Boxing Canada.

BOXING BC ASSOCIATION MEDICAL RELEASE**To be signed by the Athlete's Personal Physician**

I hereby state that I have fully and completely disclosed and described every part of my medical history, of which I have knowledge; further I have fully and completely disclosed all past and pre-existing injuries or congenital defects or any and all ailments which would potentially cause me to be unable to perform as an amateur boxer or are susceptible to being aggravated. As to all the above which I have not made full and complete disclosure, I hereby, for myself, my heirs, executors and assigns, waive and release all rights to and claim for damages I any or might have.

Signature: _____

Date: _____

Witness: _____

Dare: _____

I, _____, on this date have medically examined _____
Examining Physician *Boxer's Name*

_____, _____, and find
Street Address *City & Province*

no medical contradictions to his/ her return to competitive boxing or sparring.

Physician's Signature: _____

Date: _____

Print Physician's Name: _____

Physician's Address: _____

The boxer who receives this Restriction's Affidavit should be observed for the following symptoms during the 24 hour period following the decision listed on the reverse side of this form:

- | | |
|---|--|
| 1. Headache | 5. Mental confusion or irrational behaviour |
| 2. Increasing drowsiness or loss of consciousness following the bout. If this occurs, arouse the boxer every two hours during the night following the bout. | 6. Convulsive seizure |
| 3. Repeated vomiting | 7. Inability to move a limb |
| 4. Blurred vision | 8. Excess restlessness |
| | 9. Oozing of blood or watery fluid from ears or nose |
| | 10. Inability to control bladder or bowel |

Please forward a copy of the Medical Release to the Provincial Office via Fax: 250-964-7787 or Email: info@boxingbc.ca