

**Pre Match Declaration Form**  
(male and female)

Place and date of the competition: .....

Type of boxing competition (ordinary, Championships) .....

**Medical History Declaration**

**Athlete:** Surname..... Name .....

Date and place of Birth ..... Nationality .....

AOB  PRO  Membership N° ..... Association/Club .....

Date of last match: ..... Result .....

Date of similar sport disciplines to boxing..... Result .....

|  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| <b>Have you ever had any of the following symptoms?</b>                                |                          |                          |
| 1. Headaches   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Dizziness   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Nausea or vomiting  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Double or blurry vision   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Fainting or lost of consciousness   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Convulsions   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Have you taken prescription medicines/drugs or supplements in the last 90 days?</b> |                          |                          |
| • If so, which ones: .....   |                          |                          |
| <b>Have you been ill or had traumas in the last 120 days?</b>                          |                          |                          |
| • If so, which ones? .....   |                          |                          |

I hereby authorize you to use and process my personal details contained in this document. I commit myself to not using and drinking alcohol and/or drugs and/or abuse of medicines

Athlete's Signature or Legal Guardian: .....

In the case of minors, the Legal Guardian Mr./Ms. .... (along with a copy of personal identity document) attests that the information provided above is true and delegates the accompanying coach Mr./Ms. .... for any further correlated sanitary measures, to be present at the tournaments pre-match medical check-up, and to declare every potential use by the athlete and if the athlete has suspect symptoms

**Signature** .....

**Data** .....

**Signature of the delegate Coach**

.....

**Signature of visiting Medical Doctor pre Match**

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( Stamp and signature)