FORM B – NIAA PRE-PARTICIPATION HISTORY FORM

History Date of Exam:

Name:		Sex:		Age:		DOB:	
Grade:		School:		Sport(s)			
Address:				Phone:			
Personal Physician:							
Emergency Contact:							
Relationship:		Phone: (H)		(W)			

EXPLAIN "YES" ANSWER BELOW
CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWER TO.

	QUESTION	YES	NO
1.	Do you have a chronic medical condition (asthma, diabetes, high blood pressure, etc)?		
2.	Have you ever been hospitalized overnight?		
3.	Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?		
4.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?		
5.	a.. Have you passed out or been dizzy during exercise?		
	b. Have you had chest pain (or pressure) with exercise?		
	c. Have you had excessive unexplained shortness of breath or fatigue with exercise?		
	d. Is there a family history of premature death or morbidity from cardiovascular disease in a relative younger than age 50?		
	e. Is there any history in your family of hypertrophic cardiomyopathy, dilated cardiomyopathy long QT syndrome or Marfan's syndrome?		
	f. Has a physician denied or restricted your participation in sports for any heart problem?		
6.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?		
7.	a. Have you had a head injury or concussion?		
	b. Have you been knocked out, become unconscious, or lost your memory?		
	c. Have you had a seizure?		
	d. Do you have frequent or severe headaches?		
	e. Have you had numbness or tingling in your arms, hands, legs, or feet?		
8.	Have you become ill from exercising in the heat?		
9.	Do you cough, wheeze, or have trouble breathing during or after activity?		

	QUESTIONS (CONT'D)	YES	NO
10.	a. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?		
	b. Are you missing an eye, kidney, testicle or ovary?		
11.	a. Have you had any problems with your eyes or vision?		
	b. Do you wear glasses, contacts, or protective eyewear?		
12.	a. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints?		
	b. If *yes, check appropriate item and explain below.*		

	Head		Elbow		Hip
	Neck		Forearm		Thigh
	Back		Wrist		Knee
	Chest		Hand		Shin/Calf
	Shoulder		Finger(s)		Ankle
	Upper Arm		Foot		Toe(s)

13.	Are you actively trying to gain or lose weight?		
14.	Would you like to talk to someone about stress, anger, depression, or other issues?		
15.	Record the dates of your most recent immunizations (shots) for:		

	Tetanus		Measles
	Hepatitis B		Chicken Pox

	FEMALES ONLY	Date/Number
16.	When was your first menstrual period?	
	When was your most recent menstrual period?	
	How much time do you usually have from the start of one period to the start of another?	
	How many periods have you had in the last year?	
	What was the longest time between periods in the last year?	

EXPLAIN "YES" ANSWERS HERE:

QUESTION #	EXPLANATION

SIGNATURES (ATHLETE AND PARENT/GUARDIAN)

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

Residency/Custody Statement and the Information	
Date entered _____High School?	

ATHLETIC REGULATIONS AGREEMENT AND ASSUMPTION OF RISK

FORM D – HEALTH PRACTITIONER, please refer to the letter and references provided on FORM C.

NIAA PRE-PARTICIPATION PHYSICAL EVALUATION

(Physical to be completed during an athlete's first and third year of participation)

Physical Examination Date of Exam: ______

Name:								Date of Birth:						
Height		Weight			% Body Fat (Optional)			Pulse:		BP				
Vision:	R 20/		L 20/		Corrected	Yes		No		Pupils:	Equal		Unequal	

MEDICAL	NORMAL /ABSENT	ABNORMAL FINDINGS	EXPLAIN	INITIALS
Appearance				
Eyes/Ears/Nose/Throat				
Lymph Nodes				
Lungs				
Abdomen				
Genitalia (Males Only)				
Skin				
CARDIOVASCULAR				
Murmur that Increases from Supine to Standing				
Systolic murmur Greater than II/VI				
Any Diastolic Murmur				
Radial & Femoral Pulses				
MUSCULOSKELETAL				
Neck				
Back				
Shoulder/Arm				
Elbow/Forearm				
Wrist/Hand				
Hip/Thigh				
Knee				
Leg/Ankle				
Foot				
Stigmata of Marfan's Syndrome				

CLEARANCE

CLEARED:
Cleared after completing evaluation/rehabilitation for:

NOT CLEARED FOR:		**REASON:**	
Recommendation			

PHYSICIAN SIGNATURE

Name of Physician (print/type)		Phone:	
Address:			
	Street	City	State	Zip

I ____________________________hereby certify that I am a licensed ___________________________, qualified to perform NIAA Pre-Participation Evaluations, and that on the date set forth below, I performed all aspects of the NIAA Pre-Participation Evaluation on the above student. This student meets all physical examination requirements for participation in NIAA sanctioned sports.

Signature of Health Practitioner	**Licenses Number**	**Office Phone Number**	**Date**