

## FORM B -- NIAA PRE-PARTICIPATION HISTORY FORM

<b>HISTORY</b>	DATE OF EXAM: _____
NAME: _____	SEX: _____ AGE: _____ D.O.B.: _____
GRADE: _____	SCHOOL: _____ SPORT(S): _____
ADDRESS: _____	PHONE: _____
PERSONAL PHYSICIAN: _____	
IN CASE OF EMERGENCY, CONTACT - NAME: _____	
RELATIONSHIP: _____	PHONE (H): _____ (W): _____

<p><b>EXPLAIN "YES" ANSWERS BELOW.</b></p> <p><b>CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.</b></p>
--

	<i>YES</i>	<i>NO</i>
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 hypertropic 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?	_____	_____

**Over >**



**FORM D -- Health Practitioner, please refer to the letter & references provided on Form C.  
NIAA PRE-PARTICIPATION PHYSICAL EVALUATION  
(Physical to be completed during an athletes first and third year of participation)**

<b>PHYSICAL EXAMINATION</b>		DATE OF EXAMINATION: _____
NAME: _____		DATE OF BIRTH: _____
HEIGHT: _____	WEIGHT: _____	% BODY FAT (optional): _____ PULSE: _____ BP: ____/____ (____/____, ____/____)
VISION: R 20/ _____	L 20/ _____	CORRECTED: Y / N PUPILS: Equal _____ Unequal _____

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

**CLEARED after completing evaluation/rehabilitation for:** \_\_\_\_\_

**NOT CLEARED FOR:** \_\_\_\_\_ **REASON:** \_\_\_\_\_

**Recommendations:** \_\_\_\_\_

**Name of physician (print/type):** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_  

Street
City
State
Zip Code

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.

<b>Signature of Health Practitioner</b>	<b>License Number</b>	<b>Office Phone Number</b>	<b>Date</b>
---	-----------------------	----------------------------	-------------

Revised 5-2010; June 2012