

NIAA FORM B -- NIAA PRE-PARTICIPATION HISTORY FORM

HISTORY

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): _____

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

	<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 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?	_____	_____
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?	_____	_____

YES NO

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 below.

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

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 _____	Chickenpox _____

FEMALES ONLY

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:

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

_____ Signature of Athlete	_____ Date	_____ Signature of Parent / Legal Guardian	_____ Date
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Approved: February 2000; June 2012

Note: Physicians must sign Form B and Form D

Name of physician (print/type): _____ Phone: _____

Address: _____
Street City State Zip Code

I, _____ hereby certify that I am a licensed _____, and have reviewed the information in this FORM B prior to conducting a physical examination for the assigned student.

_____ Signature of Health Practitioner	_____ License Number	_____ Office Phone Number	_____ Date
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**NIAA FORM D -- Health Practitioner, please refer to the letter & references provided on Form C.
NIAA PRE-PARTICIPATION PHYSICAL EVALUATION**

PHYSICAL EXAMINATION		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.

Signature of Health Practitioner License Number Office Phone Number Date