

NAME:

Grade (22-23): 6 7 8

Circle all activities student is planning to participate in:

Football – Volleyball – Golf – Basketball – Track & Field – Cheer –Dance - Cross Country - Manager

FORM D -- Health Practitioner, please refer to the letter & references provided on Form C. NIAA PRE-PARTICIPATION
PHYSICAL EVALUATION
(Physical to be completed every year of participation)

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

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				

CLEARED after completing evaluation/rehabilitation for:

NOT CLEARED FOR: REASON:

Recommendations:

Name of physician (print/type): Phone:

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.

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.

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?

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.

HeadElbowHip

NeckForearmThigh

BackWristKnee

ChestHandShin/Calf

ShoulderFinger(s)Ankle

Upper ArmFootToe(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 BChickenpox

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:

Name of physician (print/type):Phone:

Address:City State Zip CodeStreet

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

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