## FORM B - - NIAA PRE-PARTICIPATION HISTORY FORM (COMPLETED THE ATHLETE'S FIRST AND THIRD YEARS OF PARTICIPATION WITH PHYSICAL)

	DATE OF FYAM			
HISTORY NAME:	SEX:	AGE:	_D.O.B.:	<u> </u>
GRADE:SCHOOL:		SPORT(S):		
ADDRESS:		PHONE:		
PERSONAL PHYSICIAN:				
IN CASE OF EMERGENCY, CONT	TACT- (NAME):	The service of the se		
RELATIONSHIP:	PHONE (H):	(W):_		
KELATIONOIII .				
	T AND UNITED ANOTHER	EDC DELOW		
EXP	LAIN "YES" ANSV ONS YOU DON'T I	ONOW THE AN	SWERS TO.	
			YES	NO
<ol> <li>Do you have a chronic medical of pressure, etc.)?</li> </ol>	ondition (asthma, diabetes	, high blood		
2. Have you ever been hospitalized				
Are you currently taking any pre- counter) medications or pills or	escriptions or non-prescrip using an inhaler?	ions (over-the-	1-1-	
4. Do you have any allergies (for e stinging insects)?	xample, to pollen, medicir	e, food, or	10 juni	
5. a. Have you passed out or bee	en dizzy during exercise?			-
b. Have you had chest pain (o	r pressure) with exercise?			
c. Have you had excessive un with exercise?	explained shortness of bre	ath or fatigue		-
<li>d. Is there a family history of vascular disease in a relative</li>	premature death or morbive younger than age 50?	dity from cardio-		-
e. Is there a history in your fa cardiomyopathy long QT s	amily of hypertrophic card syndrome or Marfan's syn	iomyopathy, dilated drome?		
f. Has a physician denied or heart problem?	restricted your participation	on in sports for any	<u>- 14.</u>	
6. Do you have any current skin p fungus or blisters)?	problems (for example, itcl	ning, rashes, acne, wa	urts,	
7. a. Have you had a head inju	ry or concussion?			-
b. Have you been knocked o	out, become unconscious, o	or lost your memory?		
c. Have you had a seizure?				-
d. Do you have frequent or				
	or tingling in your arms, h	ands, legs, or feet?		
8. Have you become ill from exe				
9. Do you cough, wheeze, or have	ve trouble breathing during	or after activity?		

			TES INO
0. a.		ective or corrective equipment or devices the or position (for example, knee brace, special our teeth, hearing aid)?	
b.	Are you missing an eye, kid	lney, testicle or ovary?	<u> </u>
1. a.	Have you had any problems	s with your eyes or vision?	<u></u>
ь.	Do you wear glasses, conta	cts or protective eyewear?	
	ave you had any problems wit ones, or joints?	th pain or swelling in muscles, tendons,	
	If yes, check appropriate it	em and explain below:	
	Head Forearm Knee Shoulder Foot	Elbow Hip Thigh Back Chest Hand Finger(s) Ankle Toe(s)	
13.	Are you actively trying to gair		
14.		eone about stress, anger, depression, or	
15.	Record the dates of your most	recent immunizations (shots) for:	
	Tetanus	Measles	
	Hepatitis B	Chickenpox	
FEM	ALES ONLY:	Andrea de la Carta de Sala de Carta de	
16.	When was your first menstrua	l period?	
17.	When was your most recent m	nenstrual period?	
18.	How much time do you usuall	ly have from the start of one period to the start of	of another?
19.	How many periods have you l	nad in the last year?	
20.	What was the longest time bet	tween periods in the last year?	_
EXP	AIN "YES" ANSWERS HI	ERE:	
a A po			19.00 f N 19.00
I he	reby state that, to the best of n	ny knowledge, my answers to the above ques	tions are complete and correct.
Sign	ature of Athlete	Signature of Parent/Guardian	Date

## FORM D -- Health Practitioner, please refer to the letter & references provided on Form C. NIAA PRE-PARTICIPATION PHYSICAL EVALUATION

			DATE OF EXAMINATION:		
AME:			DATE OF BIRTH:		
EIGHT: W	/EIGHT:	_ % BODY FAT (option	onal):PULSE:	BP;/(	
'ISION: R 20/	L 20/		CORRECTED: Y / N	PUPILS: Equal	Unequal
MEDICAL	NORMAL /ABSENT	ABNORMAL FINDINGS	EXPLAIN		INITIA
Appearance	200 10 1000				
Eyes/Ears/Nose/Throat					
Lymph Nodes					
Lungs					
Abdomen	12011-01205				
Genitalia (Males Only)					
Skin					
CARDIOVASCULAR					
Murmur that Increases					
From Supine to Standing	1.7				
Systolic Murmur Greater Than II/VI					
Any Diastolic Murmur	1.000				
Radial & Femoral Pulses					
MUSCULOSKELETAL		,			
Neck			A the state of the		
Back					
Shoulder / Arm		11 Sec. 11 14 19 10 10 10 10 10 10 10 10 10 10 10 10 10			
Elbow / Forearm					
Wrist / Hand		Established to the state of			
Hip / Thigh					
Knee					
Leg / Ankle					
Foot Stigmata of Marfan's Syndrome					
CLEARED after completing	g evaluation/re	nabilitation for: _			
NOT CLEARED FOR:			REASON:		
Recommendations:					
Name of physician (print/type):			Phone:		
Address:					
Street			City	State	Zip Code
	hereby certi	fy that I am a lice	nsed	, qualified (	o perform NIAA Pre-
, Participation Evaluations, a he above student. This stud	nd that on the lent meets all p	date set forth belo hysical examinat	ow I performed all aspection requirements for par	s of the NIAA Pre-Paticipation in NIAA sa	articipation Evaluation of anctioned sports.
Signature of Health Practiti		License N		in the second	

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