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 E – NIAA HEALTH QUESTIONNAIRE/INTERIM FORM
FOR SOPHOMORES, SENIORS and NEW STUDENTS

This evaluation should be completed ONLY if you have a physical on file from last year.

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. A positive response to any of the following questions requires a medical examination before activity can resume.

Name:		Age:		Grade:		Date:	
Address:		Phone:					
Sport:							
Date of Last Complete Sports Physical (PPE):			Where:				

SINCE YOUR LAST COMPLETE PREPARTICIPATION EXAM (PPE):

	QUESTION	YES	NO
1.	Have you had a medical illness or injury that required you to visit a physician and miss FIVE or more consecutive days of school or sports?		
2.	Have you ever been hospitalized overnight?		
3.	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?		
4.	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?		
5.	Have you become sick from exercising in the heat?		
6.	Do you cough, wheeze, or have trouble breathing during or after activity?		
7.	Have you started requiring 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)?		
8.	a. Have you had any problems with your eyes or vision?		

	QUESTIONS Continued	YES	NO
9.	Have you had any problems with sprains, dislocations, fractions, pain or swelling in the following muscles, tendons, bones, or joints that currently bother you?		

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

10.	Would you like to talk to a physician about your weight, about stress, anger, depression or any other issues?		

	FEMALES ONLY		
11.	If you have been having periods for one year or longer, have they become less regular?		

If you have answered YES to any of the above questions, please see your family physician for a complete physical

12.	Have you developed any new allergies (for example, to pollen, medicine, food, or stinging insects)? If so, please list:

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