NCSAA 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__________

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:** ________________

Address: ______________________________

Street **City** **State** **Zip Code**

I, ____________________hereby certify that I am a licensed ____________________, qualified to perform NCSAA Pre-Participation Evaluations, and that on the date set forth below I performed all aspects of the NCSAA Pre-Participation Evaluation on the above student. This student meets all physical examination requirements for participation in NCSAA sanctioned sports.

______________________________ ________________

Signature of Health Practitioner **License Number** **Office Phone Number** **Date**

May 2019

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 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 >

		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)

		YES	NO
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: ____

____

____

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**

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

** Revised 5-2010; June 2012

FORM E -- NIAA HEALTH QUESTIONNAIRE / INTERIM FORM

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(S): ____

DATE OF LAST COMPLETE SPORTS PHYSICAL (PPE): _____________ WHERE: ______________________

SINCE YOUR LAST COMPLETE PREPARTICIPATION EXAM (PPE):

		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 been hospitalized overnight	_______	_______
3.	a. Have you passed out or been dizzy with 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. Has someone in your family died, or developed serious problems, due to heart disease who was younger than 50 years old?	_______	_______
	e. Have you learned of anyone in your family who has any history of hypertropic 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. Have you developed frequent or severe headaches?	_______	
	e. Have you developed numbness or tingling in your arms, hands, legs, or feet?	_______	_______
5.	Have you become sick from exercising in the heat?	_______	_______
6.	Have you developed a 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)?	_______	

Over >

		YES	NO
8.	Have you had any problems with your eyes or vision, other than requiring glasses or contacts?	_______	_______
9.	Have you had any problems with sprains, dislocations, fractures, pain or swelling in the following muscles, tendons, bones, or joints that currently bother you?	_______	_______

If yes, check appropriate item below.

_______ 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 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:

____

____

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

Approved: February 2000: REVISED May 2001; June, 2002; June 2012