Tahoe Unified School District

Student Sports Participation/Authorization

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular maintenance examinations. This form must be completed in full and signed by the student's parent/guardian before sports screening will be complete.

Personal Information:

Student Name:_____ Birthdate:_____ Grade:_____

Street Address:_____ City:_____ State:_____

Mailing Address:_____ City_____ State:_____ Zip:_____

Mother's Name:_____ **Father's Name:**_____

Home Phone #:_____ Home Phone #:_____

Mother's Cell #:_____ Father's Cell #:_____

Mother's Work #:_____ Father's Work #:_____

Family Doctor:_____ Phone #:_____

Health Insurance Carrier:_____ Policy #:_____

Address:_____ Phone #:_____

Parent Authorization Consent to Treat a Minor

In case of an accident at school or at a school sponsored function, a representative of the school has permission to take him/her to a physician for treatment if I cannot be reached:

(check one) Yes ☐ No ☐

This authorization will remain in effect until June 30, _____.

X_____ X_____

(Parent's Signature) (Date)

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, disbetes, 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)

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 | Signature of Parent/Guardian | Date

Approved: February 2000

FORM D -- Health Practitioner, please refer to the letter & references provided on Form C.

NIAA PRE-PARTICIPATION PHYSICAL EVALUATION

(Physical to be completed during an athletes first and third 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				

CLEARANCE

CLEARED: _____

Cleared after completing evaluation/rehabilitation for: _____

_____

_____

NOT CLEARED FOR: _____ **REASON:** _____

Recommendations: _____

_____

_____

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

Address: _____

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

_____ _____

Signature of Health Practitioner **Date**

Approved: February 2000