

NATIONAL DISABILITY SPORTS ALLIANCE
Athlete Pre Participation Health Form

Date: _____ NDSA ID#: _____

Name: _____ Date of Birth: _____

Address: _____ Gender: Female Male

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Team Affiliation: _____ Social Security No.: _____

Insurance Company _____ Policy Number: _____

Emergency Contact:
Name & Relationship _____

Phone: _____

Primary Disability: Cerebral Palsy Traumatic Brain Injury Stroke Other: _____

Cause: Congenital (Present at Birth) Acquired

If acquired, please complete the following:

Date of Onset: _____
 Encephalitis/Meningitis/Infection Gun Shot Drug/Poisoning Near Drowning

Motor Vehicle Accident Other: _____

Disability Related Problems: (Check all that apply)
 Hearing Impairment Learning Disability Perceptual Motor Problems
 Visual Impairment Speech & Language Involvement

List All Past Surgeries (Procedure & Date): _____

List Any Significant Injuries With Date of Occurrence: _____

Medications You Are Currently Taking (Prescription & Over The Counter): _____

Medical History:

Date of Last Tetanus Shot: _____

High Blood Pressure No Yes Heart Disease No Yes

Asthma/Lung Disease No Yes Bladder Problems No Yes

Seizures No Yes

Type: _____
in past 12 months/Date of last seizure: _____

Diabetes No Yes---If yes, are you insulin dependent? _____

Allergies No Yes Explain: _____

Above Conditions Affecting Sports Participation No Yes Explain: _____
Other No Yes Explain: _____

NDSA Sports Classification: Track Field Swimming Indoor W/C Soccer Equestrian

For the purpose of competitive participation in the following sports: (check all that apply):

Archery Basketball Boccia Bowling Cross Country Cycling Equestrian Field
 Powerlifting Slalom Soccer Swimming Table Tennis Target Shooting Indoor W/C Soccer
 Track

Permission is given to NDSA, its representatives, a representative of the local team, or competition organizing committee to seek medical care in case of an emergency for the above named person.

Signature of participant or Parent/Guardian if person under 18 years of age _____

Date _____

**NATIONAL DISABILITY SPORTS ALLIANCE
Athlete Pre Participation Health Form Continued**

TO BE COMPLETED BY A LICENSED PHYSICIAN

Athlete's Name: _____

Diagnosis: (List All) _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____ Gender _____

Physical Exam:

	Normal	Abnormal	Explanation of Abnormality
Head/Neck	_____	_____	_____
Eyes/Vision	_____	_____	_____
Ears/Hearing	_____	_____	_____
Heart/Lungs	_____	_____	_____
G.U.	_____	_____	_____
C.N.S.	_____	_____	_____
Skin	_____	_____	_____

Orthopedic Exam:

ROM Loss/Contractures _____

Joints Laxity/Instability _____

Other _____

Significant "**Abnormal Tests**": EKG/X-Ray _____

Approval For Participation: _____ Yes _____ No

Comments/Restrictions: _____

Referral for further evaluations: _____

Physician's Signature _____ Date: _____

Print Physician's Name _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____