



**UNITED STATES ASSN of INDOOR WHEELCHAIR SOCCER**  
 Athlete Pre Participation Health Form  
 FRONT TO BE COMPLETED BY PARTICIPANT

**IWS FORM - M**  
**MEDICAL**  
**FRONT**

Date: \_\_\_\_\_ Team Affiliation: \_\_\_\_\_ USA-IWS ID#: \_\_\_\_\_  
 Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ Gender: \_\_\_\_\_ Female \_\_\_\_\_ Male  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Policy Number: \_\_\_\_\_  
**Emergency Contact:** \_\_\_\_\_  
 Name & Relationship: \_\_\_\_\_ **List All:** \_\_\_\_\_  
**Phones:** \_\_\_\_\_

**Medical History:**

**\*Primary Disability:** \_\_\_\_\_ Brain Injury (Cerebral Palsy) \_\_\_\_\_ Bone & Joint \_\_\_\_\_ Neuro-Muscular  
 \_\_\_\_\_ Spinal Cord Injury \_\_\_\_\_ Amputation \_\_\_\_\_ Other (Please List) \_\_\_\_\_  
**\*Cause:** \_\_\_\_\_ **Congenital** (Present at/or near Birth), **Or** \_\_\_\_\_ **Acquired**; If acquired, please complete the following:  
**\*Date of Onset (start):** \_\_\_\_\_ from one of the following incidents: \_\_\_\_\_ Encephalitis/Meningitis/Infection  
 \_\_\_\_\_ Gun Shot \_\_\_\_\_ Drug/Poisoning \_\_\_\_\_ Loss of Oxygen \_\_\_\_\_ Vehicle (any) Accident \_\_\_\_\_ Other?  
**\*Secondary Disability:** (Check any that apply) \_\_\_\_\_ Hearing or \_\_\_\_\_ Visual Impairment, \_\_\_\_\_ Learning Disability  
 \_\_\_\_\_ Speech & Language Involvement \_\_\_\_\_ Perceptual Motor Problems: Depth perception; Eye hand/foot Coord.

List All **Surgeries**; Any **Major Injuries** by Date (recent first): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Current Medications:** (Prescription & Over the Counter): \_\_\_\_\_  
 \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ No \_\_\_\_\_ Yes, Meds? \_\_\_\_\_  
 Heart Disease? \_\_\_\_\_ No \_\_\_\_\_ Yes; Asthma/Lung Disease \_\_\_\_\_ No \_\_\_\_\_ Yes; Bladder Issues \_\_\_\_\_ No \_\_\_\_\_ Yes  
 Seizure Active? \_\_\_\_\_ No, [In past 12 months?] \_\_\_\_\_ Yes Type: \_\_\_\_\_  
 Date of last seizure: \_\_\_\_\_ Frequency? (Ex. one/month) \_\_\_\_\_  
 Diabetes \_\_\_\_\_ No \_\_\_\_\_ Yes, If yes, **are you insulin dependent?** \_\_\_\_\_  
 Allergies \_\_\_\_\_ No \_\_\_\_\_ Yes Explain: \_\_\_\_\_

**Do Any of these Conditions Affect Sports Participation?** \_\_\_\_\_ No \_\_\_\_\_ Yes; How: \_\_\_\_\_

**Survey of sports participation; check any that apply:** \_\_\_\_\_ Archery \_\_\_\_\_ Basketball \_\_\_\_\_ Boccia \_\_\_\_\_ Bowling  
 \_\_\_\_\_ Cross Country \_\_\_\_\_ Cycling \_\_\_\_\_ Equestrian \_\_\_\_\_ Field \_\_\_\_\_ Indoor Soccer \_\_\_\_\_ Power Lifting \_\_\_\_\_ Soccer \_\_\_\_\_ Softball  
 \_\_\_\_\_ Swimming \_\_\_\_\_ Table Tennis \_\_\_\_\_ Target Shooting \_\_\_\_\_ Track

**USA-IWS Sports Classification: OFFICIAL USE ONLY**

\_\_\_\_\_ Indoor W/C Soccer \_\_\_\_\_ W/C Basketball \_\_\_\_\_ Quad Rugby

**Permission is given** to USA-IWS, 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 \_\_\_\_\_



**UNITED STATES ASSN of INDOOR WHEELCHAIR SOCCER**  
*Athlete Pre Participation Health Form*  
 BACK TO BE COMPLETED BY THE DOCTOR

IWS FORM – M  
**MEDICAL**  
 BACK

Athlete's Name: \_\_\_\_\_ TEAM AFFILIATION \_\_\_\_\_

**Diagnosis: (List All)**

\_\_\_\_\_  
 \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Gender \_\_\_\_\_

<b>Physical Exam:</b>	<u>Normal</u>	<u>Abnormal</u>	<u>Explanation of Abnormality</u>
Head/Neck	_____	_____	_____
Eyes/Vision	_____	_____	_____
Ears/Hearing	_____	_____	_____
Heart/Lungs	_____	_____	_____
G.U.	_____	_____	_____
C.N.S.	_____	_____	<b>Level of Spinal Lesion</b> _____
Skin	_____	_____	_____

**Orthopedic Exam:**

ROM Loss/Contractures \_\_\_\_\_  
 Joint Laxity/Instability/Absence \_\_\_\_\_  
 Other \_\_\_\_\_  
 Significant "**Abnormal Tests**": EKG/X-Ray \_\_\_\_\_

**Approval for Participation:**       Yes       No [Doctor must check one]

Comments/Restrictions: \_\_\_\_\_

Referral for further evaluations: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Print Physician's Name \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Bill Lardi, Interim Commissioner, [bladianddee@verizon.net](mailto:bladianddee@verizon.net)  
 UNITED STATE ASSOCIATION of INDOOR WHEELCHAIR SOCCER  
 1398 Penataquit Ave., Bayshore, NY 11706  
 Web site: [www.usaiws.org](http://www.usaiws.org)