INTERSCHOLASTIC
PREPARTICIPATION FORM
FARMINGTON SECONDARY SCHOOLS

PLEASE TURN IN A COPY OF YOUR INSURANCE CARD WITH THE PHYSICAL FORM.

Medical History – Parent/Guardian please fill out prior to examination.

Student Athlete Name *(Last, First, M.I.):*

Home Address: Grade:

Street City State Zip

DOB: AGE:

Name of Parent/Guardian

Home Address: Phone: Work:

Street City State Zip Cell:

Emergency Contact Phone: Work:

Name Relationship Cell:

Address:

Street City State Zip

SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN (CHECK ALL THAT APPLY)

Sports/Activities

☐ Baseball	☐ Football	☐ Cheer/Drill	☐ Wrestling	☐ Bowling
☐Track/Field	☐ Tennis	☐ Volleyball	☐ Golf	☐ Other_____
☐ Cross country	☐ Soccer	☐ Softball	☐ Basketball	

Please answer all health history questions on the following page PRIOR to your visit to the doctor. Please fill in the student athlete's personal information (name, gender and birth date) on each page of the form and return the entire packet to the school's athletic department.

Concussion Management

A concussion is a disturbance in the function of the brain that can be caused by a blow to the body or head and may occur in any sport or activity. Effects of a concussion may include a variety of symptoms (headache, nausea, dizziness, memory loss, balance problem) with or without a loss of consciousness. I/we understand there is a concussion management protocol established that includes care and return to play criteria.

_____ _____

Student-Athlete Signature Date

_____ _____

Parent or Legal Guardian Signature Date

Last updated 9/10/2013

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: Health History Form

Student Athlete Name_____ **Gender** ____ **DOB** _____

Parent/Guardian please fill out prior to examination

Explain "Yes" answers below

	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?	____	____
2. Do you have an ongoing medical condition (like diabetes or asthma)?	____	____
3. Are you currently taking any prescription or non-prescription medicines or pills?	____	____
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	____	____
5. Have you ever become dizzy or passed out DURING or AFTER exercise?	____	____
6. Have you ever had discomfort, pain or pressure in your chest during or after exercise?	____	____
7. Do you get more tired than your friends do during exercise?	____	____
8. Has a doctor ever told you that you have: (check all that apply) ☐ High Blood Pressure ☐ Heart Murmur ☐ Heart Infection ☐ High Cholesterol	____	____
9. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	____	____
10. Has anyone in your family ever died for no apparent reason?	____	____
11. Does anyone in your family have a heart problem?	____	____
12. Has a family member or relative died of heart problems or sudden death before the age of 50?	____	____
13. Have any of your relatives ever had any one of the following conditions? Hypertrophic cardiomyopathy, dilated cardiomyopathy, Marfan's Syndrome, or Long QT Syndrome or a significant heart arrhythmia?	____	____
14. Have you ever had a racing of your heart or skipped beats?	____	____
15. Have you ever spent the night in a hospital?	____	____
16. Have you ever had surgery?	____	____

17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game?
☐ Yes ☐ No If yes circle affected area below
18. Have you had any broken or fractured bones or dislocated joints?
☐ Yes ☐ No If yes circle affected area below
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?
☐ Yes ☐ No If yes circle affected area below

Head	Neck	Shoulder	Upper Arm	Elbow
Calf	Hand	Chest	Upper Back	Lower Back
Forearm	Thigh	Knee	Ankle Foot	Toes

20. Have you ever had a stress fracture?	____	____

	YES	NO
21. Have you ever been told you have or have had an x-ray for atlantoaxial (neck) instability?	____	____
22. Do you regularly use a brace or assistive device?	____	____
23. Has a doctor ever told you you have asthma or allergies?	____	____
24. Do you cough, wheeze or have difficulty breathing during or after exercise?	____	____
25. Is there anyone in your family with asthma?	____	____
26. Have you ever used an inhaler or taken asthma medicine?	____	____
27. Were you born without or are you missing a kidney, testicle, eye, or any other organ?	____	____
28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?	____	____
29. Do you have any rashes, pressure sores or other skin problems?	____	____
30. Have you had a herpes infection?	____	____
31. Have you had a head injury or concussion?	____	____
32. Have you been hit in the head and been confused or lost your memory?	____	____
33. Have you ever had a seizure?	____	____
34. Do you have headaches with exercise?	____	____
35. Have you ever had numbness or tingling or weakness in your arms or legs?	____	____
36. Have you ever been unable to move your arms or legs after being hit or falling?	____	____
37. When exercising in the heat, do you have severe muscle cramps or become ill?	____	____
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	____	____
39. Have you had any problems with your eyes or vision?	____	____
40. Do you wear glasses or contact lenses?	____	____
41. Do you wear protective eyewear such as goggles or a face shield?	____	____
42. Are you unhappy with your weight?	____	____
43. Are you trying to gain or lose weight?	____	____
44. Has anyone recommended you change your weight or eating habits?	____	____
45. Do you limit or carefully control what you eat?	____	____
46. Do you have concerns that you would like to discuss with the doctor/health care provider?	____	____
FEMALES ONLY:		
47. Have you ever had a menstrual period?	____	____
48. How old were you when you had your first menstrual period?	_____	
49. How many periods have you had in the last 12 months?	_____	

EXPLAIN YES ANSWERS HERE: (use back of form if necessary)

_____

_____

_____

_____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS VALID AND CORRECT:

_____ _____ _____

Student-Athlete Signature | Parent or Legal Guardian Signature | Date

I VERIFY THAT I HAVE REVIEWED THE ABOVE INFORMATION:

_____ _____

Physician Signature | Date

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM
Part B: Physical Examination
Athlete Name_____ Gender____ DOB _____

Student Athlete Name *(Last, First, M.I.):* **DOB:**

Height _____ **Weight:** _____

BMI %ile____ **Pulse:** _____ *(Per CDC %ile charts)*

Blood Pressure: _____/_____ *(Recheck if elevated)* _____/_____ _____/_____

Blood Pressure %ile_____ *(per NIH guidelines)*

Vision: R20/___L20/ ____Corrected: Y / N Pupils : Equal _____Unequal _____

MEDICAL	**Normal** *(circle one)*		**Abnormal Findings/Comments**
Appearance	YES	NO	
Eyes/Ears/Nose/Throat	YES	NO	
Hearing	YES	NO	
Lymph nodes	YES	NO	
Heart *(auscultation should be done supine and standing- abnormal findings require referral for further evaluation)*	YES	NO	
Murmurs	YES	NO	
Pulses	YES	NO	
Lungs: Auscultation	YES	NO	
Abdomen: Assessment *(incl. liver, spleen)*	YES	NO	
Genitourinary *(males only)*	YES	NO	
Skin	YES	NO	
MUSCULOSKELETAL			
Neck	YES	NO	
Back	YES	NO	
Shoulder/Arm	YES	NO	
Elbow/Forearm	YES	NO	
Wrist/Hand/Fingers	YES	NO	
Hip/Thigh	YES	NO	
Knee	YES	NO	
Leg/Ankle	YES	NO	
Foot/Toes	YES	NO	

NOTES:_____

Does Athlete wear contacts? ☐ Yes ☐ No
Does Athlete require eye protection while playing? ☐ Yes ☐ No
Does Athlete have history of Anaphylaxis? ☐ Yes ☐ No

Student MAY participate in the following types of sports (CHECK ALL THAT APPLY):
☐ **ALL FORMS OF SPORTS** ☐ CONTACT/COLLISION ☐ NON-CONTACT/STRENUOUS
☐ LIMITED CONTACT ☐ NON-CONTACT/NON-STRENUOUS
☐ STUDENT CLEARED FOR PARTICIPATION
☐ STUDENT CLEARED FOR PARTICIPATION PENDING _____
☐ STUDENT NOT CLEARED FOR PARTICIPATION

Name of Physician/Provider (print/type) _____ Date_____

Signature of Physician /Provider _____

Last updated 9/10/2013

Student's Primary Physician/Provider (for follow up, if necessary):_____

NMAA New Mexico Activities Association

CONCUSSION IN SPORTS

A Fact Sheet for Athletes and Parents

WHAT IS A CONCUSSION?

A concussion is an injury that changes how the cells in the brain normally work. A concussion is caused by a blow to the head or body that causes the brain to move rapidly inside the skull. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. Concussions can also result from a fall or from players colliding with each other or with obstacles, such as a goalpost.

WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

Observed by the Athlete

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion
- Does not "feel right"

Observed by the Parent / Guardian

- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Can't recall events after hit or fall
- Appears dazed or stunned

WHAT TO DO IF SIGNS/SYMPTOMS OF A CONCUSSION ARE PRESENT

Athlete

- TELL YOUR COACH IMMEDIATELY!
- Inform Parents
- Seek Medical Attention
- Give Yourself Time to Recover

Parent / Guardian

- Seek Medical Attention
- Keep Your Child Out of Play
- Discuss Plan to Return with the Coach

It's better to miss one game than the whole season.

Give yourself time to get better. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Second or later concussions can cause damage to your brain. It is important to rest until you get approval from a doctor or health care professional to return to play.

RETURN TO PLAY GUIDELINES UNDER THE SB1

1. Remove immediately from activity when signs/symptoms are present.
2. Must not return to full activity prior to a minimum of one week..
3. Release from medical professional required for return.
4. Follow school district's return to play guidelines.
5. Coaches continue to monitor for signs/symptoms once athletes return to activity.

Students need cognitive rest from the classroom, texting, cell phones, etc.

REFERENCES ON SENATE BILL 1 AND BRAIN INJURIES

Senate Bill 1:
http://www.nmlegis.gov/Sessions/10%20Regular/final/SB0001.pdf

For more information on brain injuries check the following websites:
http://www.nfhs.org/sportsmed.aspx
http://www.cdc.gov/concussion/HeadsUp/youth.html
http://www.stopsportsinjuries.org/concussion.aspx
http://www.ncaa.org/wps/wcm/connect/public/ncaa/Health+and+Safety/index.html

SIGNATURES

By signing below, I acknowledge that I have received and reviewed the attached NMAA's *Concussion in Sports Fact Sheet for Athletes and Parents*. I also acknowledge and I understand the risks of brain injuries associated with participation in school athletic activity, and I am aware of the State of the New Mexico's Senate Bill 1; Concussion Law.

Athlete's Signature	Print Name	Date
Parent/Guardian's Signature	Print Name	Date