



**MEDICAL EXAMINATION
FOR PARTICIPATION IN
INTERSCHOLASTIC
ATHLETICS**

(Cover sheet)

New Mexico Activities Association
6600 Palomas NE
Albuquerque, NM 87109
www.nmact.org

NOTE: The NMAA Does not need a copy of this form. Please return your school's athletic department.

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

Student Athlete Name (Last, First, M.I.):					
Home Address:				Grade:	
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>		
DOB:				AGE:	
Name of Parent/Guardian					
Home Address:				Phone:	Work:
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>	Cell:	
Emergency Contact				Phone:	Work:
<i>Name</i>	<i>Relationship</i>			Cell:	
Address:					
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>		
SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN (CHECK ALL THAT APPLY)					
Sports/Activities					
<input type="checkbox"/> Baseball	<input type="checkbox"/> Football	<input type="checkbox"/> Cheer/Drill	<input type="checkbox"/> Wrestling	<input type="checkbox"/> Bowling	
<input type="checkbox"/> Track/Field	<input type="checkbox"/> Tennis	<input type="checkbox"/> Volleyball	<input type="checkbox"/> Golf	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Cross country	<input type="checkbox"/> Soccer	<input type="checkbox"/> Softball	<input type="checkbox"/> 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.					

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

HISTORY

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

Name: (Please Print) Last _____ First _____ MI _____ Age: _____ Grade: _____ DOB: _____

Place of Birth: _____ Last School Attended: _____
City State School City State

Mailing Address: _____ Home Phone: _____
Street City State Zip

Name of Parent/Guardian: _____ Work / Cell Phone: _____

Explain "Yes" answers below

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever become dizzy or passed out During or After exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family with asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had chest discomfort, pain or pressure during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you get more tired than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever told you that you have: (check all that apply)	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High blood pressure			29. Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart infection			30. Have you had a herpes infection?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol			31. Have you had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever ordered a test for your heart? (ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has anyone in your family ever died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had seizure?	<input type="checkbox"/>	<input type="checkbox"/>
11. Does anyone in your family have a heart condition starting under the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has a family member or relative died of heart problems or sudden death before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness or tingling or weakness in your arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have any of relatives ever had one of the following conditions? Hypertrophic cardiomyopathy, Marfan's syndrome, Long QT syndrome or a significant heart arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been unable to move your arms or legs after being hit or fallen?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had racing of your heart or skipped heart beats?	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
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? (if Yes, circle below)	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones or dislocated joints? (if yes, circle below)	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections rehabilitation, physical therapy, a brace, a cast or crutches?	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
Head Neck Shoulder Upper arm Elbow			43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
Calf Hand Chest Upper back Lower back			44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
Forearm Thigh Knee Ankle Foot Toes			45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you have concerns that you would like to discuss with the doctor / health care provider?	<input type="checkbox"/>	<input type="checkbox"/>

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:

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

Student-Athlete Signature _____ Parent or Court Appointed Legal Guardian Signature _____ Date _____

I VERIFY THAT I HAVE REVIEWED THE ABOVE INFORMATION

Physician Signature _____ Date _____

CLEARANCE FORM

Athlete Name: _____ Gender _____ DOB _____

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

Contact/Collision	Limited Contact	Strenuous	Non-Contact
		Strenuous	Non-strenuous
Field Hockey	Baseball	Discus	Bowling
Football	Basketball	Javelin	Golf
Ice Hockey	Cheerleading	Shot put	
Lacrosse	Diving	Rowing	
Soccer	Fencing	Running/Cross Country	
Wrestling	Field	Strength Training	
	High Jump	Swimming	
	Pole vault	Tennis	
	Gymnastics	Track	
	Skiing		
	Softball		
	Volleyball		

Student MAY participate in the following types of sports: (CHECK ALL THAT APPLY)

STUDENT CLEARED FOR 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

STUDENT ATHLETE EMERGENCY INFORMATION

ALLERGIES _____ HISTORY OF ANAPHYLAXIS? Yes No

IMMUNIZATIONS Up to date Last Tetanus Immunization _____

Significant Medical History Information (Please include any history of asthma, hypertension, previous head injury, unequal pupil size etc.)

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

Current Medical Conditions:

Current Medications (if on asthma medication please indicate if needed prior to sports):

Does Athlete wear contacts? Yes No Does Athlete require eye protection while playing? Yes No

Providers Name _____ MD DO NP PA DC Phone: _____

Address:

Street City State Zip

Signature of Provider _____ Date: _____

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

PHYSICAL EXAMINATION

Athlete Name _____ Gender _____ DOB _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____ / _____, (_____ / _____, _____ / _____)

Vision: R 20/ _____ L 20/ _____ Corrected: Y _____ N _____ Pupils: Equal _____ Unequal _____

MEDICAL	Normal	Abnormal	Findings/Comments
Appearance			
(any physical finding of Marfan's syndrome)			
Eyes/Ears/Nose/Throat (if indicated)			
Hearing (if indicated)			
Heart (auscultation should be done supine and standing- abnormal findings require referral for further evaluation)			
Murmurs			
Pulses			
Lungs: Auscultation			
Abdomen:			
Genitourinary (only if indicated)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

NOTES: _____

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 PENDING (explanation) _____
- STUDENT NOT CLEARED FOR PARTICIPATION (explanation) _____

Name of Physician/Provider (print/type) _____	Date _____
Signature of Physician /Provider _____	
Student's Primary Physician/Provider (for follow up, if necessary): _____	

Sport Concussion Information Paper

A concussion is a disturbance in the function of the brain caused by a blow to the body or head, occurring in any sport or activity

Signs to watch for:

- * Headache
- * Nausea
- * Dizziness
- * Problems with Memory
- * Balance problems

Problems could arise over the first 24-48 hours. You should not be left alone and must go to a hospital at once if you:

- * Have a headache that gets worse
- * Are very drowsy or can't be awakened (woken up)
- * Can't recognize people or places
- * Have repeated vomiting
- * Behave unusually or seem confused, are very irritable
- * Have seizures (arms and legs jerk uncontrollably)
- * Are unsteady on your feet; have slurred speech

Remember: it is better to be safe. Consult your doctor after a suspected concussion.

Remember, concussion should be suspected in the presence of ANY ONE or more of the following:

- * Symptoms (such as a head ache), or
- * Signs (such as loss of consciousness), or
- * Memory problems

Any athlete with a suspected concussion should be monitored for deterioration (i.e., should not be left alone) and should not drive a motor vehicle.

Return to play:

Athletes should not be returned to play the same day of injury.

When returning athletes to play, they should follow a stepwise symptom-limited program, with stages of progression.

For example:

1. Rest until asymptomatic (physical and mental rest)
2. Light aerobic exercise (e.g. stationary bike)
3. Sport-specific exercise (running, jogging, lateral movement)
4. Non-contact training drills (start light resistance training)
5. Full contact training after medical clearance
6. Return to competition (game play)

There should be approximately 24 hours (or longer) for each stage and the athlete should return to stage 1 if symptoms recur. Resistance training should only be added in the later stages. Medical clearance should be given before return to play, and the athlete must have NO symptoms.

We, the student athlete and parent or court appointed guardian acknowledge and agree that we have read, understand, and will abide by the above stated conditions.

Student-Athlete Signature

Date

Parent or Court Appointed Legal Guardian Signature

Date