

The New Mexico Activities Association physical form provides schools, parents and providers with a recommended form.

If the NMAA recommended Physical Form is to be used, please ensure that your child's school grants permission to use this form and that no additional documentation is needed to gain athletic participation eligibility (i.e. parental permission form).



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 to your school's athletic department.

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

Student Athlete Name (<i>Last, First, M.I.</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.

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

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		YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?	___	___	21. Have you ever been told you have or have had an x-ray for atlantoaxial (neck) instability?	___	___
2. Do you have an ongoing medical condition (like diabetes or asthma)?	___	___	22. Do you regularly use a brace or assistive device?	___	___
3. Are you currently taking any prescription or non-prescription medicines or pills?	___	___	23. Has a doctor ever told you you have asthma or allergies?	___	___
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	___	___	24. Do you cough, wheeze or have difficulty breathing during or after exercise?	___	___
5. Have you ever become dizzy or passed out DURING or AFTER exercise?	___	___	25. Is there anyone in your family with asthma?	___	___
6. Have you ever had discomfort, pain or pressure in your chest during or after exercise?	___	___	26. Have you ever used an inhaler or taken asthma medicine?	___	___
7. Do you get more tired than your friends do during exercise?	___	___	27. Were you born without or are you missing a kidney, testicle, eye, or any other organ?	___	___
8. Has a doctor ever told you that you have: (check all that apply)	___	___	28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?	___	___
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur			29. Do you have any rashes, pressure sores or other skin problems?	___	___
<input type="checkbox"/> Heart Infection <input type="checkbox"/> High Cholesterol			30. Have you had a herpes infection?	___	___
9. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	___	___	31. Have you had a head injury or concussion?	___	___
10. Has anyone in your family ever died for no apparent reason?	___	___	32. Have you been hit in the head and been confused or lost your memory?	___	___
11. Does anyone in your family have a heart problem?	___	___	33. Have you ever had a seizure?	___	___
12. Has a family member or relative died of heart problems or sudden death before the age of 50?	___	___	34. Do you have headaches with exercise?	___	___
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?	___	___	35. Have you ever had numbness or tingling or weakness in your arms or legs?	___	___
14. Have you ever had a racing of your heart or skipped beats?	___	___	36. Have you ever been unable to move your arms or legs after being hit or falling?	___	___
15. Have you ever spent the night in a hospital?	___	___	37. When exercising in the heat, do you have severe muscle cramps or become ill?	___	___
16. Have you ever had surgery?	___	___	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	___	___
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes circle affected area below			39. Have you had any problems with your eyes or vision?	___	___
18. Have you had any broken or fractured bones or dislocated joints? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes circle affected area below			40. Do you wear glasses or contact lenses?	___	___
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes circle affected area below			41. Do you wear protective eyewear such as goggles or a face shield?	___	___
Head Neck Shoulder Upper Arm Elbow			42. Are you unhappy with your weight?	___	___
Cal f Hand Chest Upper Back Lower Back			43. Are you trying to gain or lose weight?	___	___
Forearm Thigh Knee Ankle Foot Toes			44. Has anyone recommended you change your weight or eating habits?	___	___
20. Have you ever had a stress fracture?	___	___	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 (<i>Last, First, M.I.</i>): DOB: _____	Height _____ Weight: _____
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BMI %ile _____ <small>(Per CDC %ile charts)</small>	Pulse: _____	Blood Pressure: _____ / _____ <small>(Recheck if elevated)</small>	Blood Pressure %ile _____ <small>(per NIH guidelines)</small>
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Vision: R20/ ___ L20/ ___ Corrected: Y / N Pupils : Equal _____ Unequal _____

MEDICAL	Normal (<i>circle one</i>)		Abnormal Findings/Comments
Appearance	YES	NO	
Eyes/Ears/Nose/Throat	YES	NO	
Hearing	YES	NO	
Lymph nodes	YES	NO	
Heart (<i>auscultation should be done supine and standing- abnormal findings require referral for further evaluation</i>)	YES	NO	
Murmurs	YES	NO	
Pulses	YES	NO	
Lungs: Auscultation	YES	NO	
Abdomen: Assessment (<i>incl. liver, spleen</i>)	YES	NO	
Genitourinary (<i>males only</i>)	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 _____

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