**Albuquerque Public School** **Athletic Physical** **General Information**

**Name** _____ **School Year:** _____

**SPORTS:** _____

## Parent(s)/Legal Guardina(s) and Student-Athlete Participation in Athletics :

**PLEASE READ THE FOLLOWING STATEMENTS CONCERNING PARTICIPATION IN AN ALBUQUERQUE PUBLIC SCHOOL (APS) INTERSCHOLASTIC ATHLETIC PROGRAM AND RESPOND WITH YOUR SIGNATURE(S) .**

**Consent to Participate**

Consent is hereby given for the named student to engage in interscholastic athletics as approved by APS and represent _____ as a member.

Name of school

Please list any sports that consent to participate is not allowed for the above student:_____

**Financial Responsibility for Medical Care:**

Is agreed that financial responsibility for securing care of athletic injuries is a matter between the parent(s)/legal guardian(s) and the health care provider. APS will not pay health care providers for the treatment of any students.

**Transportation Responsibilities:**

It is further agreed that the parent(s)/legal guardian(s) and student will assume the legal responsibilities for the personal safety and action of the above named student while traveling to and from practices and games when transportation is not provided by APS. When transportation is provided by APS, policy requires students use such transportation to and from. Any exceptions must be arranged with the school prior to departure and in accordance with the athletic travel policy.

**Acknowledgement of Injury Risk:**

**We the parent(s)/legal guardian(s) and the student-athlete are aware that preparation for and participation in interscholastic athletics involves a risk of serious and permanent Injury to the student-athlete. We understand and acknowledge the danger of these severe injuries as inherent in physical –activity.**

**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 loss of consciousness.

I/we understand there is a concussion management protocol established that includes care and return to play criteria. To review the APS established protocol for concussion management, visit the APS athletic website or contact the school athletic trainer.

**Notification of Injuries:**

In order to protect the student-athlete at all times, APS Athletic trainers will share information concerning the care, disposition, and treatment of athletic injuries only with the treating physician, team physician, athletic trainer, and coaches on a need to know basis only for the time that the student is in high school. Any information released to a third parties by school health providers will be done only with permission of the parent/legal guardian and student.

**Physical Examinations:**

Physical exams are required by the NMAA for all athletic participants. The physical exam must be dated April 1 or after for it to be valid for the following school year. Athletic Physical exams dated prior to April 1 of a calendar years will not be valid upon the NMAA starting date for sports during that following school year.

Name _____ School Year _____

**Authorization of Health Care Services:**

I/We designate the team coach of his/her designee to act in my/our behalf to authorize such hospitalization, medical attention, surgery, and any other health care services as may be recommended in an emergency because of illness or injuries while preparing for or participation in interscholastic athletics. Every attempt will be made to make contact with parent(s)/legal guardian(s) prior to making any decision if at all possible without prolonging care for the student-athlete. I/We herby assume all financial responsibility for all hearth care services provided.

**Accidental/Health Care Insurance:**

Accidental/Health insurance is a requirement, prior to tryout, practice, or participation in interscholastic athletics. Insurance can be purchased from a private carrier or from a carrier contracted through APS at a nominal rate. Please contact your school for the application**. APS does not cover athletic injuries and will not assume the financial responsibility for heath care services.**

_____ **is covered for accidental/health care insurance.**
Name of student-athlete

**A** ☐ **APS Health/Accident Insurance carrier**
**Applied for insurance at** _____ **on** _____
School Date

**B** ☐ **Personnel Health/Accident Insurance Carrier** _____
**(Name of Carrier)**

## EMERGENCY CONTACT INFORMATION

| NAME | DATE OF BIRTH | AGE |
|---|---|---|
| | | |

| PARENT /LEGAL GUARDIAN NAME | HOME PHONE | WORK PHONE | CELL PHONE |
|---|---|---|---|
| | | | |

| PARENT /LEGAL GUARDIAN NAME | HOME PHONE | WORK PHONE | CELL PHONE |
|---|---|---|---|
| | | | |

| EMERGENCY CONTACT | RELATIONSHIP | PHONE CONTACT | PHONE CONTACT |
|---|---|---|---|
| | | | |

Medications(s) Student-Athlete is taking: _____

Known allergies to Medication of Foods: _____

Known Medical Problems: _____

**We the parent(s)/Legal guardian(s) and the student-athlete have completely read, fully understand, and voluntarily accept and agree with all of the above terms and conditions (pages 1 & 2). We verify all information is correct.**

_____ _____ _____
Parent/Legal Guardian Signature Date Relationship

_____ _____
Student-Athlete Signature Date

# Albuquerque Public Schools

**HISTORY FORM**

*(Note: This form is to be filled out by the student-athlete and parent prior to seeing the physician.)*

Name_____ Date of Birth_____

Gender_____ Age_____ Grade_____ School_____ Sport(s) _____

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

**Explain "Yes" answers below. Circle questions you don't know the answers to.**

| GENERAL QUESTIONS | Yes | No |
|---|---|---|
| 1. Has a doctor ever denied your participation in sports for any reason? | | |
| 2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____ | | |
| 3. Have you ever spent the night in the hospital? | | |
| 4. Have you ever had surgery? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High Blood Pressure ☐ A heart murmur ☐ High Cholesterol ☐ A heart infection ☐ Kawasaki Disease Other: _____ | | |
| 9. Has a doctor ever ordered a test for your heart? (For example: ECG/EKG, echocardiogram) | | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| 11. Have you ever had an unexplained seizure? | | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | | |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)? | | |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | |
| 15. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator? | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning? | | |
| **BONE AND JOINT QUESTIONS** | **Yes** | **No** |
| 17. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss practice or a game? | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches? | | |
| 20. Have you ever had a stress fracture? | | |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | | |
| 22. Do you regularly use a brace, orthotics, or other assistive device? | | |
| 23. Do you have bone muscle or joint injury that bothers you? | | |
| 24. Do any of your joints become painful, swollen, feel warm or look red? | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | |

| Medical Questions | Yes | No |
|---|---|---|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 28. Is there anyone in your family who has asthma? | | |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area | | |
| 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 33. Have you had herpes or MRSA skin infection? | | |
| 34. Have you ever had a head injury or concussion? | | |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 36. Do you have a history of seizure disorder? | | |
| 37. Do you have headaches with exercise? | | |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 40. Have you ever become ill while exercising in the heat? | | |
| 41. Do you get frequent muscle cramps when exercising? | | |
| 42. Do you or someone in your family have sickle cell trait or disease? | | |
| 43. Have you had any problems with your eyes or vision? | | |
| 44. Have you had any eye injuries? | | |
| 45. Do you wear glasses or contact lenses? | | |
| 46. Do you wear protective eyewear, such as goggles or a face shield? | | |
| 47. Do you worry about your weight? | | |
| 48. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 49. Are you on a special diet or do you avoid certain types of foods? | | |
| 50. Have you ever had an eating disorder? | | |
| 51. Do you have any concerns that you would like to discuss with a doctor? | | |
| | | |
| **FEMALES ONLY** | **Yes** | **No** |
| 52. Have you ever had a menstrual period? | | |
| 53. How old were you when you had your first menstrual period? | | |
| 54. How many periods have you had in the last 12 months? | | |
| | | |
| | | |

**Explain "Yes" answers here**

**I hereby state that to, the best of my knowledge, my answers to the above questions are complete and correct.**

**Signature of athlete**_____**Signature of parent/guardian**_____**Date**_____

**Adapted from 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society of Sports Medicine, and American Osteopathic Academy of Sports Medicine.**

**Aug 2012**

# Albuquerque Public School

# PHYSICAL EXAMINATION FORM

NAME _____ DATE OF BIRTH _____

## PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you feel safe at your home or residence?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   Do you drink alcohol or use any other drugs?
   - Do you wear a seat belt, use a helmet, and use condoms?

## EXAMINATION

**Height** _____ **Weight** _____ BMI _____ **Gender-** ☐ Male ☐ Female

**BP**_____/_____(_____/_____) **Pulse** _____ **Vision** R 20/_____ L 20/_____ Corrected ☐ Y ☐ N Contacts ☐ Glasses ☐

| MEDICAL | NORMAL | ABNORMAL FINDINGS |
|---|---|---|
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | |
| Eyes/ears/nose/throat • Pupils equal • Hearing | | |
| Lymph nodes | | |
| Heart [a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)[b] | | |
| Skin<br>• HSV, lesions suggestive of MRSA, tinea corporis | | |
| Neurologic [c] | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional<br>• Duck-walk, single leg hop | | |

[A] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[B] Consider GU exam if in private setting. Having third party present is recommended.
[C] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

## Clearance for Participation

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for(Note recommendations):

☐ Not cleared Reason:_____
☐ Pending further evaluation _____
☐ For any sports _____
☐ For certain sports _____

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician (print/type) _____ Date _____
Address _____ Phone _____
Signature of physician _____

# 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 SB137

1. Remove immediately from activity when signs/symptoms are present.
2. Must not return to full activity prior to a minimum of 240 hours (10 days).
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 137 AND BRAIN INJURIES

Senate Bill 137:
http://www.nmlegis.gov/Sessions/16%20Regular/final/SB0137.pdf

For more information on brain injuries check the following websites:
http://www.nfhs.org/resources/sports-medicine
http://www.cdc.gov/concussion/HeadsUp/youth.html
http://www.stopsportsinjuries.org/concussion.aspx
http://www.ncaa.org/health-and-safety/medical-conditions/concussions

## 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 137; Concussion Law.

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