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 *(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 Court Appointed 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
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		
20. Have you ever had a stress fracture?	___	___

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

	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 proplems 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 Court Appointed 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 7/18/2013

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