



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 Court Appointed Legal Guardian 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: _____
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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 (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 _____

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