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 History - Parent/Guardian please fill out prior to examination.

Student Athlete Name (Last, First, M.I.):

Home Address:  
Street  
City  
State  
Zip  
Grade:

DOB:

AGE:

Name of Parent/ Guardian

Home Address:  
Street  
City  
State  
Zip  
Phone:  
Work:

Cell:

Emergency Contact

Name  
Relationship

Phone:  
Work:

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 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

<table>
<thead>
<tr>
<th>Explain &quot;Yes&quot; answers below</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in sports for any reason?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>2. Do you have an ongoing medical condition (like diabetes or asthma)?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3. Are you currently taking any prescription or non-prescription medicines or pills?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>4. Do you have allergies to medicines, pollen, foods, or stinging insects?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>5. Have you ever become dizzy or passed out during exercise?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>6. Have you ever had discomfort, pain or pressure in your chest during or after exercise?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>7. Do you get more tired than your friends during exercise?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>8. Has a doctor ever told you that you have: (check all that apply)</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>□ High Blood Pressure □ Heart Murmur</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>□ Heart Infection □ High Cholesterol</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>9. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>10. Has anyone in your family ever died for no apparent reason?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>11. Does anyone in your family have a heart problem?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>12. Has a family member or relative died of heart problems or sudden death before the age of 50?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>13. Have any of your relatives ever had any one of the following conditions?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Hypertrophic cardiomyopathy, dilated cardiomyopathy, Marfan's Syndrome, or Long QT Syndrome or a significant heart arrhythmia?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>14. Have you ever had a racing of your heart or skipped beats?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>15. Have you ever spent the night in a hospital?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>16. Have you ever had surgery?</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>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</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>18. Have you had any broken or fractured bones or dislocated joints? □ Yes □ No If yes circle affected area below</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>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</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>20. Have you ever had a stress fracture?</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

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 (Last, First, M.I.): DOB:

<table>
<thead>
<tr>
<th>Height _________</th>
<th>Weight: ________</th>
</tr>
</thead>
</table>

BMI %ile____ Pulse: _____ Blood Pressure: ____/____
(Per CDC %ile charts) (Recheck if elevated) ____/____

Blood Pressure %ile____
(per NIH guidelines)

Vision: R20/___L20/ ____Corrected: Y / N

Pupils: Equal _______Unequal__________

MEDICAL

<table>
<thead>
<tr>
<th>Appearance</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes/Ears/Nose/Throat</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Hearing</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Lymph nodes</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Neck</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Shoulder/Arm</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Elbow/Forearm</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Wrist/Hand/Fingers</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Knee</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Leg/Ankle</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Foot/Toes</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

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): ________________________________

Last updated 9/10/2013
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

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