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 *(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 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

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

	YES	NO
20. Have you ever had a stress fracture?	__	__
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 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:**		**Height** _____ **Weight:** _____
BMI %ile____ *(Per CDC %ile charts)* **Pulse:** _____	**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 _____

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