



Sports Physical Forms

(Forward to School A.D.)

SY: 2022 ~ 2023

Student Name: _____ D.O.B.: _____

Gender: () Male () Female Age: _____

Grade: _____ () Day Student

(Dorm Student: Pending until further notice due to COVID)

1. Parent/Guardian Name: _____

2. Parent/Guardian Name: _____

Home Phone No.: () _____

Work Phone No.: () _____

Message Phone No.: () _____

Cellular Phone No.: () _____

Date of Examination: _____

Do you have asthma? () yes () no

If yes, please provide additional information: _____

Do you have any allergy? () yes () no

If yes, please provide additional information: _____

Gallup Indian Medical Clinic/PHS Chart No.: _____

Name of other Medical Clinic: _____

If you have any questions please call A.D. (Athletic Director) at (505) 488- 6300.

Parent/Guardian:

Please make a copy for your own record keeping,

Original document to A.D.

Per NMAA Bylaw 6.15, the New Mexico Activities Association approved sports physical packet must be used for all pre-participation examinations and all forms must be submitted to your school prior to participation.

The packet includes the following forms:

1. Emergency Information Form
2. Medical History Form
3. Physical Examination Form
4. Consent to Treat Form



MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

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.

Emergency Information – Parent/Guardian please fill out prior to examination.

Student Athlete Name (Last, First, M.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>	
Emergency Contact				Cell:
<i>Name</i>	<i>Relationship</i>			Work:
Address:				Cell:
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>	
Participant Insurance: Participants must be covered by accident/injury insurance prior to participation.				
Insurance Carrier		Policy Number		Group ID
SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN (CHECK ALL THAT APPLY)				
Sports/Activities				
<input type="checkbox"/> Baseball	<input type="checkbox"/> Cheer	<input type="checkbox"/> Football	<input type="checkbox"/> Softball	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Basketball	<input type="checkbox"/> Cross Country	<input type="checkbox"/> Golf	<input type="checkbox"/> Tennis	<input type="checkbox"/> Wrestling
<input type="checkbox"/> Bowling	<input type="checkbox"/> Dance	<input type="checkbox"/> Soccer	<input type="checkbox"/> Track/Field	<input type="checkbox"/> Other _____
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.				

COVID-19 ACKNOWLEDGEMENT

I am aware that there is an inherent risk of injury and/or illness associated with participation in athletic activity and grant permission for my child to participate in NMAA activities during the current COVID-19 pandemic.

Student-Athlete Signature

Date

Parent or Court Appointed Legal Guardian Signature

Date

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____

Have you had COVID-19? (check one): Y N

Have you been immunized for COVID-19? (check one): Y N If yes, have you had: One shot Two shots

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). _____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS

(Explain "Yes" answers at the end of this form.)

Circle questions if you don't know the answer.

	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		

HEART HEALTH QUESTIONS ABOUT YOU

	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU

(CONTINUED)

	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____

Date of birth: _____

PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
Vision: R 20/ L 20/		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: <input type="checkbox"/> Y <input type="checkbox"/> N		
Administered COVID-19 vaccine at this visit: <input type="checkbox"/> Y <input type="checkbox"/> N		
If yes: <input type="checkbox"/> First dose <input type="checkbox"/> Second dose		
MEDICAL		
Appearance	NORMAL	ABNORMAL FINDINGS
<ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 		
Eyes, ears, nose, and throat		
<ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart ^a		
<ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin		
<ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis 		
Neurological		
MUSCULOSKELETAL		
Neck	NORMAL	ABNORMAL FINDINGS
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional		
<ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 		

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

- Medically eligible for all sports without restriction
- Medically eligible for all sports with recommendations for further evaluation or treatment of _____
- Medically eligible for certain sports _____
- Not medically eligible pending further evaluation
- Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional _____

_____, MD, DO, NP, or PA

NEW MEXICO ACTIVITIES ASSOCIATION

6600 PALOMAS AVE. NE
ALBUQUERQUE, NM 87109
PHONE: 505-923-3110
FAX: 505-923-3114



CONSENT TO TREAT FORM

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances, it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, as a member of the New Mexico Activities Association (NMAA), _____ (name of school or district) requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/NMAA, to the extent the QMP deems necessary to prevent harm to the student/athlete. It is understood that a QMP may be an athletic trainer, medical/osteopathic physician, physician assistant or nurse practitioner licensed by the state of New Mexico (or the state in which the student/athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by New Mexico law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designated by state regulation and standing protocols, and not for the purpose of making decisions about return to play.

PLEASE PRINT LEGIBLY OR TYPE

"I, _____ the undersigned, am the parent/legal guardian of, _____ a minor and student-athlete at _____ (name of school or district) who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/NMAA may employ or designate QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the designated state license, except as otherwise limited by New Mexico law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/NMAA."

Date: _____ Signature: _____



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

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 SB38

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 38 AND BRAIN INJURIES

Senate Bill 38:

<https://www.nmlegis.gov/Sessions/17%20Regular/final/SB0038.pdf>

For more information on brain injuries check the following websites:

<https://nfhslearn.com/courses/61059/concussion-for-students>

<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, parent/guardian and athlete acknowledge the following:

- ◆ Both have received and reviewed the attached NMAA's *Concussion in Sports Fact Sheet for Athletes and Parents*.
- ◆ Both understand the risks of brain injuries associated with participation in school athletic activity, and are aware of the State of the New Mexico's Senate Bill 38; Concussion Law.
- ◆ Athlete has received brain injury training pursuant to Senate Bill 38.

Athlete's Signature

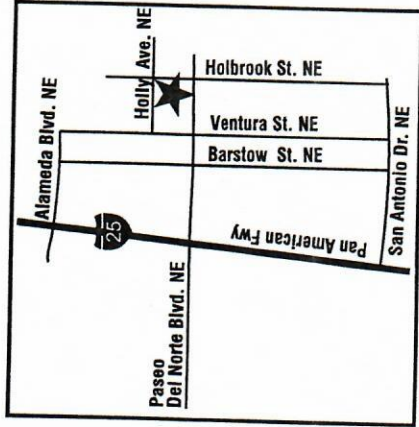
Print Name

Date

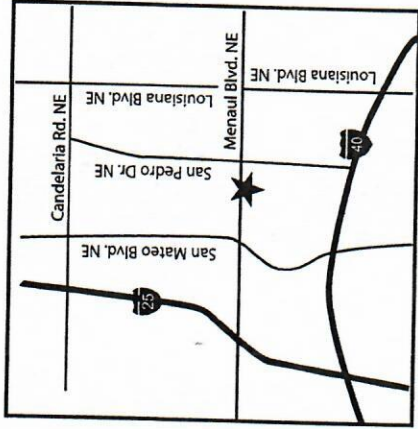
Parent/Guardian's Signature

Print Name

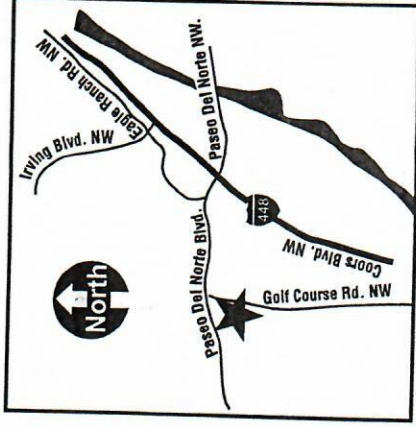
Date



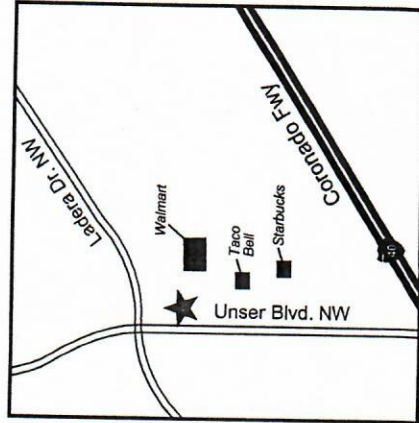
9551 Paseo Del Norte Blvd. NE #D
 Albuquerque, NM 87122



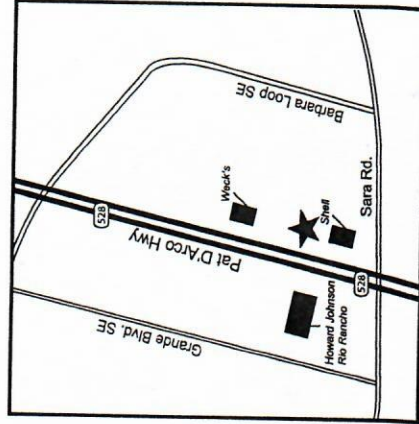
5504 Menaul Blvd. NE #F
 Albuquerque, NM 87110



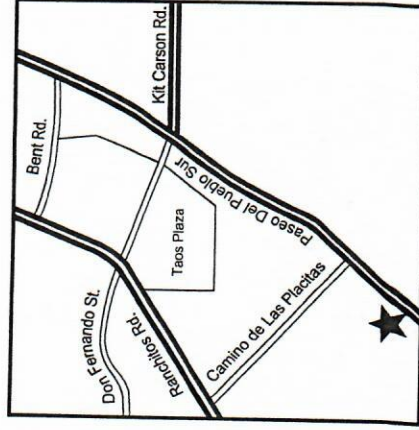
8201 Golf Course Road NW #A3
 Albuquerque, NM 87120



1800 Unser Blvd., #500
 Albuquerque, NM 87120



1630 Rio Rancho Dr. SE #101
 Rio Rancho, NM 87124



330 C Paseo Del Pueblo Sur
 Taos, NM 87571