

**MEDICAL EXAMINATION  
FOR PARTICIPATION IN  
BELEN HIGH SCHOOL ATHLETICS**

**Medical History** – Parent/Guardian please fill out prior to examination

<b>Student Athlete Name (Last, First, M.I.):</b>				
Home Address:				
Grade	Student ID #	DOB:	Age:	
<b>Parent/Guardian Information</b>				
Name:		Relationship:		
Phone:	Work:	Cell:		
Name:		Relationship:		
Phone:	Work:	Cell:		
<b>Alternate Emergency Contact</b>	Name:	Phone:		
	Relationship:	Work:		
<b>SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN (CHECK ALL THAT APPLY)</b>				
<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.				

**TO GRANT CONSENT**

In case of an emergency involving my child and I cannot be reached, I hereby give consent to transport my child to the following medical care providers and hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary:

Doctor \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Dentist \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Nurse Practitioner/Physician Assistant \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Hospital \_\_\_\_\_ Phone (    ) \_\_\_\_\_

If, for any reason, the above listed medical care providers or hospital cannot be reached, I authorize appropriate transport and medical care of my child to any appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Parent/Guardian please complete form out prior to examination**

**PARENTAL CONSENT**

Please read the following statements concerning the participation of your child/ward in interscholastic athletics. Respond below with your signature.

I hereby give my consent for \_\_\_\_\_ to participate in interscholastic athletics at Belen High School/Belen Middle School, and authorize the Belen Schools to provide the information on this form to the New Mexico Activities Association. The financial responsibility for securing care of athletic injuries is a matter between the parent/guardian and physician or dentist of parent's/guardian's selection. The Belen Schools may not pay doctors, dentists or hospitals for any treatment of any child.

**INSURANCE**

**\*\*\*Student MUST have health insurance in order to participate in athletics and proof of insurance is mandatory. (I.e. copy of insurance card)**

**We have health insurance with \_\_\_\_\_**

**My student has student accident insurance through Belen High School.  
Check here \_\_\_\_\_**

**\*\*School insurance forms are available in the office\*\***

**ACKNOWLEDGMENT OF INJURY RISKS**

We, the parent(s)/guardian(s) and student-athlete, are aware that preparation for and participation in interscholastic athletics involves many risks of serious and permanent injury to the student-athlete. We understand and acknowledge the danger of these severe injuries as inherent in physical activity that may involve vigorous physical contact.

We parent(s)/guardian(s) and student-athlete have completely read, fully understand and voluntarily accept and agree to all of the above terms and conditions.

**DOCTOR MEDICAL RELEASE OF INJURIES**

I will not hold the head athletic trainer, Belen High School, or Belen Consolidated Schools liable for any further injury or damage to my student athlete in the event that they are not informed about an athletic injury. **Furthermore, I will get a doctor's note to inform the above listed of my student athlete's playing status, diagnosis, and any rehabilitation needed.**

**PERSONAL MEDICATION NOTIFICATION**

For my own protection, I the student-athlete will inform the athletic trainer and / or medical doctors if I am taking any medication or using any ointment, liniments, and balms or have a metal implant in my body BEFORE receiving therapy or treatment of any kind in the training room.

Any combination of the above and deep heat therapy could cause serious complications.

We, parent(s)/guardian(s) and student-athlete, have read and understand the preceding statements and agree to their content.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENT/GUARDIAN'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENT/GUARDIAN'S SIGNATURE

## Sport Concussion Information Paper

(Parent and Athlete Read and Sign)

**A concussion is a disturbance in the function of the brain caused by a blow to the body or head, causing 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.**

### Signs to watch for:

- Headache
- Nausea
- Dizziness
- Loss of Memory
- Problems with Balance
- Double or Blurred Vision
- Vacant Stare, Dilated Eyes
- Slurred or incoherent speech
- Emotional
- Bothered by light or noise
- Feeling sleepy or groggy
- Ringing in ears
- Personality Change
- Confusion and inability to focus

Problems could arise over the first 24-48 hours. **Any athlete with a suspected concussion should be monitored for deterioration (i.e., should not be left alone) and should not drive a motor vehicle.**

### You must go to a hospital at once if you:

- Have a headache that gets worse
- Very drowsy or can't be awakened
- Can't recognize people or places or recall events
- Have repeated Vomiting
- Behave unusually or seem confused, irritable
- Have seizures
- Are unsteady on your feet
- Slurred Speech

Remember: it is better to be safe: **Consult your doctor after a suspected concussion.**

### Return to play:

1. Remove immediately from activity when signs/symptoms are present!!!!
2. Athletes should NOT be returned to play the same day of injury.
3. Release from a medical profession is required for return.
4. Must be asymptomatic for one week before return to play.
4. Continue to monitor for signs/symptoms once athlete returns to play.

### Resources:

**FOR MORE INFORMATION ABOUT 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/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>

**We the student-athlete and parent or court appointed guardian acknowledge and agree that we have read, understand, and will abide by the above stated conditions.**

\_\_\_\_\_  
**Student-Athlete Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or Court Appointed Legal Guardian Signature**

\_\_\_\_\_  
**Date**

# ATHLETIC PRE-PARTICIPATION PHYSICAL FORM

## Part A: Health History Form

Student Athlete Name \_\_\_\_\_ Student ID# \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_

1. Has a doctor ever denied or restricted your participation in sports for any reason?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	23. Has a doctor ever told you that you have asthma or allergies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
2. Do you have an ongoing medical condition (like diabetes or asthma)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
3. Are you currently taking any prescription or nonprescription (over-the counter) medicines or pills?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	25. Is there anyone in your family with asthma?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
				26. Have you ever used an inhaler or taken asthma medicine?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
5. Have you ever become dizzy or passed out <b>DURING or AFTER</b> exercise?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
6. Have you ever had discomfort, pain, or pressure in your chest during or after exercise?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	29. Do you have any rashes, pressure sores or other skin problems?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
7. Do you get more tired than your friends do during exercise?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	30. Have you had herpes infection?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
8. Has a doctor ever told you that you have: <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Infection <input type="checkbox"/> High Cholesterol (Check all that apply)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	31. Have you had a head injury or concussion?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
				32. Have you been hit in the head and been confused or lost your memory?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
9. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	33. Have you ever had a seizure?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
10. Has anyone in your family ever died for no apparent reason?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	34. Do you have headaches with exercise?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
11. Does any one in your family have a heart problem?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	35. Have you ever had numbness or tingling or weakness in your arms, legs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
12. Has a family member or relative died of heart problems or sudden death before the age of 50?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	36. Have you ever been unable to move your arms or legs after being hit or fallen?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	37. When exercising in the heat, do you have severe muscle cramps or become ill?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
				38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
14. Have you ever had racing of your heart or skipped heartbeats?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	39. Have you had any problems with your eyes or vision?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
15. Have you ever spent the night in a hospital?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	40. Do you wear glasses or contact lenses?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
16. Have you ever had surgery?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	41. Do you wear protective eyewear such as goggles or a face shield?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes circle affect area below:  18. Have you had any broken or fractured bones or dislocated joints? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes circle affect area below:				42. Are you unhappy with your weight?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
				43. Are you trying to gain or lose weight?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
				44. Has anyone recommended you change your weight or eating habits?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
				45. Do you limit or carefully control what you eat?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
				46. Do you have concerns that you would like to discuss with the doctor/health care provider?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Head	Neck	Shoulder	Upper Arm	Elbow	Calf or Shin	Hand	Chest	<b>FEMALES ONLY:</b> 47. Have you had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No 48. How old were you when you had your first menstrual period? _____ 49. How many periods have you had in the last 12 months? _____	
Upper back	Lower Back	Forearm	Thigh	Knee	Hip	Ankle	Foot Toes		
20. Have you ever had a stress fracture?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Explain "Yes" answers here (use the back of the form if necessary):</b> _____ _____ _____					
21. Have you ever been told that you have or have had an x-ray for atiantoaxial (neck) instability?		<input type="checkbox"/> Yes	<input type="checkbox"/> No						
22. Do you regularly use a brace or assistive device?		<input type="checkbox"/> Yes	<input type="checkbox"/> No						

# ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

## Part B: Physical Examination

TO BE COMPLETED BY THE EXAMINING PHYSICIAN OR PROVIDER – PLEASE COMPLETE BOTH PAGES

Student Athlete Name (Last, First, M.I.) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
**BMI %ile** \_\_\_\_\_ **Pulse** \_\_\_\_\_ **Blood Pressure:** \_\_\_\_\_ / \_\_\_\_\_ **Blood Pressure %ile** \_\_\_\_\_  
 (Per CDC %ile charts) (Recheck if elevated) \_\_\_\_\_ / \_\_\_\_\_ (per NIH guidelines)  
 \_\_\_\_\_ / \_\_\_\_\_  
 Vision: R20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Corrected: Y/N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

MEDICAL	Normal (circle one)		Abnormal Findings/Comments
	Yes	No	
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 require any mouth protection while playing?  Yes  No

**STUDENT ATHLETE EMERGENCY INFORMATION**

HISTORY OF ANAPHYLAXIS  Yes  No

IMMUNIZATIONS  Up to date

Last Tetanus Immunization \_\_\_\_\_

**Significant Medical History** *Information (Please include any history of asthma, hypertension, previous head injury, unequal pupil size etc.)*

Student's Primary Physician/Provider *(For follow up, if necessary)* \_\_\_\_\_

**Current Medical Conditions:**

**Allergies:**

**Current Medications (if on asthma medication please indicate if needed prior to sports):**

Provider's Name	_____	____MD____DO____NP____PA	Phone: _____
-----------------	-------	--------------------------	--------------

Address:	_____	_____	_____	_____
	Street	City	State	Zip

Signature of Provider	_____	Date: _____
-----------------------	-------	-------------

**STUDENT CLEARED FOR ALL FORMS OF SPORTS**

CONTACT/COLLISION     NON-CONTACT/STRENUOUS     LIMITED CONTACT     NON-CONTACT-STRENUOUS

STUDENT CLEARED FOR PARTICIPATION  
 STUDENT CLEARED FOR PARTICIPATION PENDING \_\_\_\_\_  
 STUDENT NOT CLEARED FOR PARTICIPATION