**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 Court Appointed Legal Guardian Signature Date

# PREPARTICIPATION PHYSICAL EVALUATION
# HISTORY FORM

*(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)*

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

**Explain "Yes" answers below. Circle questions you don't know the answers to.**

| GENERAL QUESTIONS | Yes | No |
|---|---|---|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | | |
| 2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____ | | |
| 3. Have you ever spent the night in the hospital? | | |
| 4. Have you ever had surgery? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____ | | |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) | | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| 11. Have you ever had an unexplained seizure? | | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | | |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? | | |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | |
| **BONE AND JOINT QUESTIONS** | **Yes** | **No** |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | |
| 20. Have you ever had a stress fracture? | | |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | | |
| 22. Do you regularly use a brace, orthotics, or other assistive device? | | |
| 23. Do you have a bone, muscle, or joint injury that bothers you? | | |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | |

| MEDICAL QUESTIONS | Yes | No |
|---|---|---|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 28. Is there anyone in your family who has asthma? | | |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 33. Have you had a herpes or MRSA skin infection? | | |
| 34. Have you ever had a head injury or concussion? | | |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 36. Do you have a history of seizure disorder? | | |
| 37. Do you have headaches with exercise? | | |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 40. Have you ever become ill while exercising in the heat? | | |
| 41. Do you get frequent muscle cramps when exercising? | | |
| 42. Do you or someone in your family have sickle cell trait or disease? | | |
| 43. Have you had any problems with your eyes or vision? | | |
| 44. Have you had any eye injuries? | | |
| 45. Do you wear glasses or contact lenses? | | |
| 46. Do you wear protective eyewear, such as goggles or a face shield? | | |
| 47. Do you worry about your weight? | | |
| 48. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 49. Are you on a special diet or do you avoid certain types of foods? | | |
| 50. Have you ever had an eating disorder? | | |
| 51. Do you have any concerns that you would like to discuss with a doctor? | | |
| **FEMALES ONLY** | | |
| 52. Have you ever had a menstrual period? | | |
| 53. How old were you when you had your first menstrual period? | | |
| 54. How many periods have you had in the last 12 months? | | |

**Explain "yes" answers here**

_____

_____

_____

_____

_____

_____

_____

_____

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete _____ Signature of parent/guardian _____ Date _____



HE0503 9-2681/0410

# Preparticipation Physical Evaluation
# PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

## PHYSICIAN REMINDERS

1. 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, 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 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?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

| **EXAMINATION** | | |
|---|---|---|
| Height Weight ☐ Male ☐ Female | | |
| BP / ( / ) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart[a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)[b] | | |
| Skin<br>• HSV, lesions suggestive of MRSA, tinea corporis | | |
| Neurologic[c] | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional<br>• Duck-walk, single leg hop | | |

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

# 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/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, 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 |