ALBUQUERQUE PUBLIC SCHOOLS
ATHLETIC PHYSICAL PACKET

Consent and General Information

COMPLETE FORMS IN BLUE/BLACK INK ONLY

Student Name_____ **School Year**_____ **Grade**_____

Sport(s)_____

Parent(s)/Legal Guardian(s): Read the following statements concerning participation in an Albuquerque Public Schools (APS) interscholastic athletic/extracurricular activity program. A parent/legal guardian is required to review the following information and acknowledge by initialing after each section.

Acknowledgement of Injury Risk: I/we the parent(s)/legal guardian(s) and the named student acknowledge that preparation for and participation in interscholastic athletics involves a risk of serious and permanent injury to a student. We understand and acknowledge the danger of these severe injuries as inherent in the physical activity/contact in all sports. **Initial**_____

Consent to Participate: I/we give consent for the named student to participate in APS interscholastic athletics and/or extracurricular activities as provided by APS and represent the school listed below as a team/group member in accordance with the policies and conditions set forth by the school district, school administration and coaches/sponsors. **Initial**_____

Name of School_____

List any sports/activities that consent to participate is **not** given for the named student_____

Financial Responsibility for Medical Care: It is agreed financial responsibility for securing care of athletic injuries is a matter between the parent(s)/legal guardian(s) and the health care provider. APS will not be liable for payment of health care providers for the treatment of the named student. **Initial**_____

Physical Examinations: Physical exams are required by the New Mexico Activities Association (NMAA) for all athletic participants who wish to participate in tryouts, practices and events. The physical exam must be dated **April 1 or later** for it to be valid for the following school year. Athletic physical exams dated **prior** to April 1 of a calendar year will not be valid upon the NMAA starting date for sports in the following school year. **Initial**_____

Consent to Treat: I/we give consent to any supervising coach and/or qualified medical professional (QMP) associated with the APS interscholastic athletic program/extracurricular activity program to arrange for a certified athletic trainer (ATC), EMT or physician to render and provide immediate medical treatment, emergency techniques and/or short/long term treatment to the named student as it relates to injuries that are sustained while participating in such APS sports/activities. **Initial**_____

Notification of Injuries: In order to protect a student at all times, APS athletic trainers will share information concerning the care, disposition and treatment of athletic injuries only with a student's school athletic trainer, treating physician, team physician, school nurse and team coach on a need to know basis for the time the student is participating at the school. Information released to a third party by school health care providers may only occur with written permission of the parent/legal guardian. **Initial**_____

Concussion Management: A concussion is a disruption in the normal function of the brain that can be caused by a bump, blow or jolt to the head or a penetrating head injury that may occur in any sport or activity. Effects of a concussion may include a variety of symptoms (e.g. headache, nausea, dizziness, memory loss, etc.) with or without loss of consciousness. I/we understand there is a concussion management protocol established that includes extensive care and return to play criteria. **Initial**_____

Transportation Responsibilities: It is agreed that the parent(s)/legal guardian(s) and student will assume the legal responsibilities for the personal safety and action of the named student while traveling to and from practices and games when transportation is not provided by APS. When transportation is provided by APS, policy requires students use such transportation to and from practices and games. Any exceptions must be arranged with the school athletic director/school administration prior to departure and in accordance with athletic travel policy. **Initial**_____

Student Name _____ Date of Birth _____ Grade _____ School Year _____

Authorization of Health Care Services

I/We designate the team coach or qualified medical professional or his/her designee to act in my/our behalf to authorize such hospitalization, medical attention, surgery, and any other health care services as may be recommended in an medical situation because of illness or injuries while preparing for or participation in interscholastic athletics. Every attempt will be made to make contact with parent(s)/legal guardian(s) prior to making any decision if at all possible without prolonging care for the student. I/We hereby assume all financial responsibility for all health care services provided.

EMERGENCY CONTACT INFORMATION

PARENT/LEGAL GUARDIAN NAME	HOME PHONE	WORK PHONE	CELL PHONE
PARENT/LEGAL GUARDIAN NAME	HOME PHONE	WORK PHONE	CELL PHONE
SECONDARY EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE	CELL PHONE

List medications student is taking: _____

_____

List known allergies to medications and/or foods: _____

_____

List known medical issues: _____

_____

Accidental/Health Care Insurance

Accidental/Health insurance is a requirement, prior to tryout, practice, or participation in interscholastic athletics. Insurance can be purchased from a private carrier or from a carrier contracted through APS at a nominal rate. Please contact your school for the application**. I/We understand APS does not cover athletic injuries and APS will not assume the financial responsibility for health care services while participation in any school activity/interscholastic athletic program or event.**

(NAME OF STUDENT) _____ **is covered by accidental/health care insurance.**

A ☐ **APS Health/Accident Insurance carrier**
Applied for insurance at _____ **on** _____
SCHOOL DATE

B ☐ **Personal Health/Accident Insurance Carrier** _____
NAME OF INSURANCE COMPANY

I/We the parent(s)/legal guardian(s) and the student have completely read, fully understand and voluntarily accept and agree with all of the above terms and conditions on PAGES 1 AND 2. I/We verify all information is correct.

_____ _____ _____
Parent/Legal Guardian Signature Date Relationship

_____ _____
Student-Athlete Signature Date

This form shall be with the coach/athletic trainer at all events.

ALBUQUERQUE PUBLIC SCHOOLS — Medical History Information

*(Note: This form is to be filled out by the student-athlete and parent/legal guardian **prior** to seeing the physician.)*

Student Name_____ Date of Birth_____ Grade_____ School Year _____

Gender_____ Age_____ 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 in the boxes below. Circle questions you do not know the answer to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied 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? **IF YES, PLEASE CIRCLE**		
15. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator? **IF YES, PLEASE CIRCLE**		
16. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning? **IF YES, PLEASE CIRCLE**		
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 practice or a game? **IF YES, PLEASE CIRCLE**		
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? **IF YES, PLEASE CIRCLE**		
20. Have you ever had a stress fracture? If yes, where?		
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 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?		
Explain YES answers BELOW:		

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? **IF YES, PLEASE CIRCLE**		
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? **IF YES, PLEASE CIRCLE**		
33. Have you had 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? **IF YES, PLEASE CIRCLE**		
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. Have you ever taken any supplements to help you gain or lose weight?		
50. Are you on a special diet or do you avoid certain types of foods?		
51. Have you ever had an eating disorder?		
MENTAL HEALTH QUESTIONS	**Yes**	**No**
52. Do you feel stressed out or under a lot of pressure?		
53. Do you ever feel sad, hopeless, depressed, anxious or have suicidal thoughts?		
54. Do you feel safe at your home or residence?		
55. Have you ever tried or used cigarettes, electronic cigarettes, chewing tobacco, snuff or dip? **IF YES, PLEASE CIRCLE**		
56. Do you drink alcohol or use any other drugs?		
57. Have you ever taken anabolic steroids or used any other performance enhancement supplements?		
58. Do you wear a seat belt, use a helmet, use condoms?		
59. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
60. Have you ever had a menstrual period?		
61. How old were you when you had your first menstrual period?		
62. How many periods have you had in the last 12 months?		
Explain YES answers BELOW:		

I hereby state that to the best of my knowledge, the answers to the above questions are complete and correct. I understand it is my responsibility as the parent(s)/legal guardian(s) to notify the physician if there are any unique individual problems that are not listed in the above medical history information.

Parent/Legal Guardian Printed_____ Parent/Legal Guardian Signature_____Date _____

Student Name Printed_____ Student Signature_____Date_____

Adapted from 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society of Sports Medicine, and American Osteopathic Academy of Sports Medicine.

ALBUQUERQUE PUBLIC SCHOOLS **Physical Examination Form**

Student Name _____ **Date of Birth** _____ **Grade** _____ **School Year** _____

EXAMINATION

Height _____ **Weight** _____ **BMI** _____ **Gender** ☐ Male ☐ Female

BP _____/_____ (_____ / _____) **Pulse** _____ **Vision** R 20/ _____ L 20/ _____ Corrected Yes ☐ No ☐ Contacts ☐ Glasses ☐

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional • 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.

CLEARANCE FOR PARTICIPATION

☐ CLEARED for all sports without restriction

☐ CLEARED for all sports without restriction with recommendations for further evaluation or treatment **(recommendations below as necessary)**

☐ NOT CLEARED ☐ pending further evaluation ☐ for any sports ☐ for specific sports **(explanation below as necessary)**

_____

_____

_____

I have examined and reviewed the medical history of the above named student-athlete and completed the pre-participation physical evaluation. The student-athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the student-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 student-athlete and parent(s)/legal guardian(s).

Name of Physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of Physician _____

Adapted from 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society of Sports Medicine, and American Osteopathic Academy of Sports Medicine.

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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