Before turning in your physical to the athletic department please make sure you have completed the following:

1) All papers requiring a parent signature are signed.
2) A copy of your athlete's insurance card is attached.
3) Make sure all 6 pages have been completed.

Thank you for your help with this completion of the physical forms.

MEDICAL EXAMINATION
FOR PARTICIPATION IN
BELEN HIGH SCHOOL ATHLETICS

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

Student Athlete Name *(Last, First, M.I.):*			
Home Address: Street	City	State	Zip
Grade	Student ID #	DOB:	Age:
Parent/Guardian Information			
Name:		Relationship:	
Phone:	Work:	Cell:	
Name:		Relationship:	
Phone:	Work:	Cell:	
Alternate Emergency Contact	Name:	Phone:	
	Relationship:	Work:	

SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN (CHECK ALL THAT APPLY)

❑ **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.

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 _____

-Complete Form on Other Side-

Month/Year Student Entered 8th Grade _____

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, occurring in any sport or activity

Signs to watch for:

- Headache
- Nausea
- Dizziness
- Problems with Memory
- Balance problems

Problems could arise over the first 24-48 hours. You should not be left alone and must go to a hospital at once if you:

- Have a headache that gets worse
- Are very drowsy or can't be awakened (woken up)
- Can't recognize people or places
- Have repeated vomiting
- Behave unusually or seem confused, are very irritable
- Have seizures (arms and legs jerk uncontrollably)
- Are unsteady on your feet; have slurred speech

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

Remember, concussion should be suspected in the presence of ANY ONE or more of the following:

- Symptoms (such as a head ache), or
- Signs (such as loss of consciousness), or
- Memory problems

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.

Return to play:

Athletes should not be returned to play the same day of injury.

When returning athletes to play, they should follow a stepwise symptom-limited program, with stages of progression. For example:

1. Rest until asymptomatic (physical and mental rest)
2. Light aerobic exercise (e.g. stationary bike)
3. Sport-specific exercise (running, jogging, lateral movement)
4. Non-contact training drills (start light resistance training)
5. Full contact training after medical clearance
6. Return to competition (game play)

There should be approximately 24 hours (or longer) for each stage and the athlete should return to stage 1 if symptoms recur. Resistance training should only be added in the later stages. Medical clearance should be given before return to play, and the athlete must have NO symptoms.

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?	❑ Yes	❑ No	23. Has a doctor ever told you that you have asthma or allergies?	❑ Yes	❑ No
2. Do you have an ongoing medical condition (like diabetes or asthma)?	❑ Yes	❑ No	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	❑ Yes	❑ No
3. Are you currently taking any prescription or nonprescription (over-the counter) medicines or pills?	❑ Yes	❑ No	25. Is there anyone in your family with asthma?	❑ Yes	❑ No
			26. Have you ever used an inhaler or taken asthma medicine?	❑ Yes	❑ No
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	❑ Yes	❑ No	27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ?	❑ Yes	❑ No
5. Have you ever become dizzy or passed out **DURING or AFTER** exercise?	❑ Yes	❑ No	28.Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?	❑ Yes	❑ No
6. Have you ever had discomfort, pain, or pressure in your chest during or after exercise?	❑ Yes	❑ No	29. Do you have any rashes, pressure sores or other skin problems?	❑ Yes	❑ No
7. Do you get more tired than your friends do during exercise?	❑ Yes	❑ No	30. Have you had herpes infection?	❑ Yes	❑ No
8. Has a doctor ever told you that you have: ❑ High Blood Pressure ❑ Heart Murmur ❑ Heart Infection ❑ High Cholesterol (Check all that apply)	❑ Yes	❑ No	31. Have you had a head injury or concussion?	❑ Yes	❑ No
			32. Have you been hit in the head and been confused or lost your memory?	❑ Yes	❑ No
9. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	❑ Yes	❑ No	33. Have you ever had a seizure?	❑ Yes	❑ No
10. Has anyone in your family ever died for no apparent reason?	❑ Yes	❑ No	34. Do you have headaches with exercise?	❑ Yes	❑ No
11. Does any one in your family have a heart problem?	❑ Yes	❑ No	35. Have you ever had numbness or tingling or weakness in your arms, legs?	❑ Yes	❑ No
12. Has a family member or relative died of heart problems or sudden death before the age of 50?	❑ Yes	❑ No	36. Have you ever been unable to move your arms or legs after being hit or fallen?	❑ Yes	❑ 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?	❑ Yes	❑ No	37. When exercising in the heat, do you have severe muscle cramps or become ill?	❑ Yes	❑ No
			38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	❑ Yes	❑ No
14. Have you ever had racing of your heart or skipped heartbeats?	❑ Yes	❑ No	39. Have you had any problems with your eyes or vision?	❑ Yes	❑ No
15. Have you ever spent the night in a hospital?	❑ Yes	❑ No	40. Do you wear glasses or contact lenses?	❑ Yes	❑ No
16. Have you ever had surgery?	❑ Yes	❑ No	41. Do you wear protective eyewear such as goggles or a face shield?	❑ Yes	❑ 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? ❑ **Yes** ❑ **No** If yes circle affect area below:			42. Are you unhappy with your weight?	❑ Yes	❑ No
			43. Are you trying to gain or lose weight?	❑ Yes	❑ No
18. Have you had any broken or fractured bones or dislocated joints? ❑ **Yes** ❑ **No** If yes circle affected area below:			44. Has anyone recommended you change your weight or eating habits?	❑ Yes	❑ No
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 affect area below:			45. Do you limit or carefully control what you eat?	❑ Yes	❑ No
			46. Do you have concerns that you would like to discuss with the doctor/health care provider?	❑ Yes	❑ No

Head	Neck	Shoulder	Upper Arm	Elbow	Calf or Shin	Hand	Chest
Upper back	Lower Back	Forearm	Thigh	Knee	Hip	Ankle	Foot Toes

FEMALES ONLY:

47. Have you had a menstrual period? ❑ Yes ❑ 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?_____

20. Have you ever had a stress fracture?	❑ Yes	❑ No
21. Have you ever been told that you have or have had an x-ray for atiantoaxial (neck) instability?	❑ Yes	❑ No
22. Do you regularly use a brace or assistive device?	❑ Yes	❑ No

Explain "Yes" answers here (use the back of the form if necessary):

_____

_____

_____

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM
Part B: Physical Examination
Athlete Name_____ Gender_____ DOB_____

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_____
(Per CDC %ile charts)

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 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