Hope Christian School Physical Exam Form

☐ Athletic ☐ Non-Athletic

Physical exams are required for all 6th-12th grade students attending Hope Christian School, and must be dated after **April 1st**. These forms must be turned in to the Health Office which is located in the High School Office no later than **July 15th**.

Student Information (Please print legibly)

Student Name_____ Grade:_____ D.O.B._____

Address _____City _____ Zip _____

Parents or Guardians Names _____

Address (if different from student) _____
City _____ Zip _____

Parents or Guardians Phone Numbers: Home _____ Work _____

Cell(s) _____ _____

Family Physician _____Physician's Phone Number _____

PRIMARY INSURANCE

Co. Name_____ Phone #_____

Co. Address_____

City_____ State_____ Zip Code_____

Group #_____ Policy #_____

Please check any sport in which student may be participating:

( ) Baseball	( ) Drill	( ) Softball	( ) Volleyball
( ) Basketball	( ) Football	( ) Swim	( ) Other_____
( ) Cheer	( ) Golf	( ) Tennis	
( ) Cross-Country	( ) Soccer	( ) Track	

STUDENT ATHLETE EMERGENCY INFORMATION

HISTORY OF ANAPHYLAXIS ☐ YES ☐ NO

IMMUNIZATIONS ☐ Up to Date

DATE OF LAST TETANUS IMMUNIZATION _____

KNOWN MEDICAL CONDITIONS (*Please include any history of asthma, hypertension, previous head injury, etc.):*

CURRENT MEDICATIONS:

ALLERGIES:

PARENTAL CONSENT/RELEASE OF LIABILITY:

As the parent or legal guardian of the student, I give my permission for him/her to participate in school activities and the sports activities indicated on the previous page. I understand that there is a risk of injury in participating in school activities and athletic activities. I confirm that my child is covered by an accident insurance policy. I will be responsible for any injury incurred by my child. I hereby agree to indemnify, release, defend, and hold harmless Hope Christian Schools, Inc., and its staff for any expenses or for any injury suffered by my child while participating in school or sports activities, unless such injury is due to gross negligence on the part of any of those entities or individuals. I hereby give my consent for _____to engage in school activities and if indicated, interscholastic athletics, as are approved by Hope Christian Schools, Inc., and represent Hope Christian School as a team member on trips. I have reviewed the Medical History form with my child and, to the best of my knowledge, the information provided is accurate.

Signature of Parent or Guardian:_____ Date:_____

PARENT/GUARDIAN CONSENT TO TREATMENT:

I/We herby authorize any HCS school representative on my behalf to consent to any medical treatment deemed necessary by any licensed physician/surgeon in the event of illness or injury. If, in the judgment of any representative of the school the student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by school representative; and I do hereby agree to indemnify and hold harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student. If at all possible without prolonging care for the student, every reasonable attempt will be made by school representatives to make contact with the parents or legal guardians prior to consenting to medical treatment.

Signature of Parent or Guardian:_____ Date:_____

Medical History

(To be completed prior to medical examination by student and parent/legal guardian)

Student Name:_____ **Grade:**_____

1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐ Yes	☐ No	19. Is there anyone in your family with asthma?	☐ Yes	☐ No
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐ Yes	☐ No	20. Have you ever used an inhaler or taken asthma medicine?	☐ Yes	☐ No
3. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐ Yes	☐ No	21. Have you had a head injury or concussion?	☐ Yes	☐ No
4. Have you ever become dizzy or passed out DURING or AFTER exercise?	☐ Yes	☐ No	22. Have you been hit in the head and been confused or had memory loss?	☐ Yes	☐ No
5. Have you ever had discomfort, pain, or pressure in your chest DURING or AFTER exercise?	☐ Yes	☐ No	23. Have you ever had a seizure?	☐ Yes	☐ No
6. Has a doctor ever told you that you have (circle all that apply): High Blood Pressure Heart Infection High Cholesterol Heart Murmur	☐ Yes	☐ No	24. Have you ever had numbness, tingling, or weakness in your extremities?	☐ Yes	☐ No
7. Has a doctor ever ordered a test for your heart (i.e. EKG, ECG)?	☐ Yes	☐ No	25. Have you ever been unable to move your arms or legs after being hit or falling?	☐ Yes	☐ No
8. Has anyone in your family ever died for no apparent reason?	☐ Yes	☐ No	26. Have you had any problems with your eyes or vision?	☐ Yes	☐ No
9. Does anyone in your family have a heart problem?	☐ Yes	☐ No	27. Do you wear glasses or contacts?	☐ Yes	☐ No
10. Has a family member died of heart problems before the age of 50?	☐ Yes	☐ No	28. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐ Yes	☐ No
11. Have any of your relatives ever had any one of the following: Hypertrophic Cardiomyopathy, Marfan's Syndrome, Long QT Syndrome, or heart arrhythmia	☐ Yes	☐ No	29. When exercising in the heat, do you have severe muscle cramps or illness?	☐ Yes	☐ No
12. Have you ever had racing of your heart or skipped heartbeats?	☐ Yes	☐ No	30. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a game/practice? *(If yes, list the location or area)*	☐ Yes	☐ No
13. Have you ever spent the night in the hospital?	☐ Yes	☐ No	31. Have you had any broken/fractured bones or dislocated joints? *(Please list)*	☐ Yes	☐ No
14. Have you ever had surgery?	☐ Yes	☐ No	32. Have you ever had a stress fracture? *(Please list location/area)*	☐ Yes	☐ No
15. Have you ever been told that you have or have had an x-ray for neck instability?	☐ Yes	☐ No	33. Have you had an injury that required an MRI, CT, x-rays, rehabilitation, physical therapy, a cast, or injection?	☐ Yes	☐ No
16. Has a doctor ever told you that you have asthma?	☐ Yes	☐ No	**Explain "YES" answers here (use the back of the form if necessary):** _____		
17. Do you regularly use a brace or assistive device?	☐ Yes	☐ No	_____		
18. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐ Yes	☐ No	_____		

Physical Examination

Student's Name _____ Birth Date_____
Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

	Normal	Abnormal	Comments
MEDICAL			
Appearance *(any physical finding of Marfan's Syndrome)*			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart *(murmurs)*			
Pulses			
Lungs			
Abdomen			
Genitourinary *(hernia)* ***Athletes Only***			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

NOTES:_____
_____

Clearance

I verify that I have reviewed the Medical History information provided and after exam clear student for the following:

Student-Athlete MAY participate in the following types of sports (CHECK ALL THAT APPLY):

_____ALL FORMS OF SPORTS/ACTIVITIES
_____Contact/Collision (Football, Soccer)
_____Non-Contact/Strenuous (Baseball, Basketball, Cheer, High Jump, Pole Vault, Softball, Volleyball)
_____Limited Contact/Non-Contact (Cross-Country, Track, Drill, Swim, Tennis, Golf)
_____ STUDENT CLEARED FOR PARTICIPATION PENDING (explanation)
_____ STUDENT **NOT** CLEARED FOR PARTICIPATION (explanation)
_____
_____

Name, Address, Phone of Physician/Provider_____
_____

Signature of Provider_____ Date_____

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.

REFERENCES ON SENATE BILL 1 AND BRAIN INJURIES

Senate Bill 1:
www.nmact.org
-or-
http://legis.state.nm.us/Sessions/10%20Regular/final/SB0001.pdf

For more information on brain injuries check the following websites:
http://www.nfhs.org/sportsmed.aspx
www.cdc.gov/ConcussionInYouthSports
www.stopsportsinjuries.org/concussion
http://www.ncaa.org

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 New Mexico's Senate Bill 1; Concussion Law.

_____	_____	_____
Athlete's Signature	Print Name	Date
_____	_____	_____
Parent/Guardian's Signature	Print Name	Date

Please make sure you have completed the following before turning in your physical to the High School Health Office:

1) All papers requiring a parent/guardian signature are signed

2) Make sure the NMAA Concussion Information form is signed by both the parent and the student, if participating in athletics

3) Make sure all 4 pages of the physical form have been completed

Thank you!