# LOS LUNAS SCHOOLS

**P.O. Drawer 1300, Los Lunas, NM 87031**

( Los Lunas HS)
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## Pre-Participation Physical Exam Packet

******PLEASE PRINT CLEARLY!!!!******

Current Physical (dated after April 1, 2015)

**Parent/ Guardian please fill out prior to examination.**

Student Athlete Name (Last, First, M.I.):_____

Home Address: _____

Grade: _____Age:_____ ID#:_____

Name of Parent/Guardian:_____

Home Address:_____

Phone (H):_____Work:_____ Cell: _____

Emergency Contact: (other than parents):

Name:_____ Relationship:_____

Phone (H):_____ Work:_____ Cell:_____

Address: _____

### Sport/Activity Student will participate in (Check all that apply)

| FALL | WINTER | SPRING |
|---|---|---|
| Football _____ | Boys Basketball ____ | Baseball ____ |
| Cross Country_____ | Girls Basketball ____ | Boys Golf ____ |
| Boys Soccer _____ | Wrestling ____ | Girls Golf ____ |
| Girls Soccer _____ | Swimming _____ | Softball ____ |
| Volleyball _____ | | Boys Track ____ |
| JAGZ _____ | JR ROTC _____ | Girls Track ____ |
| Cheer _____ | | |

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 on each page of the form and return the entire packet along with a copy of your insurance card to the school's athletic trainer

**Certified Athletic Trainers:** **Los Lunas HS Brett Schram** **Valencia HS Joshua Sears**

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# CLEARED TO PARTICIPATE & EMERGENCY INFORMATION FORM

Student Athlete Name:_____ Grade:_____ ID#_____

- *This student has turned in the following information to the VHS Athletic Trainer. To the best of my knowledge it is complete and accurate and this student is now cleared to begin practicing/ participating.*
  ***The Head Coach is responsible for having this document readily available for travel.***

## Emergency Information:

Mother's Name :_____Phone:(H)_____(W)_____(C)_____
Father's Name:_____ Phone: (H)_____ (W)_____(C)_____
Home Address:_____

*Emergency contact (other than parent):*
Name: _____ (relationship) Phone: _____ (Cell)_____
Name: _____ (relationship) Phone: _____ (Cell)_____

## Medical History:

ALLERGIES:_____ HISTORY OF ANAPHYLAXIS:___Y___N

IMMUNIZATIONS: __ (up to date) Last Tetanus Immunization: _____
Significant Medical History Information ( Please indicate any history of asthma, hypertension, previous head injury, unequal pupil size etc).

_____
_____
Current Medical Conditions: _____
_____
Current Medications (if asthma medication please indicate if needed prior to sports):
_____
Does athlete wear contacts? __Y__N Does athlete require eye protection while playing? __Y__N
Student's Primary Physician/ Provider (For follow up, if necessary):_____
Address: _____ Phone: _____

Hospital Preference: _____(1st choice)_____ (2nd Choice)

Insurance Provider: _____ Policy #: _____

**OFFICE USE ONLY:**
**VHS Athletic Trainer** _____ **Date**: _____
(*There may be other circumstance that make this student ineligible and preclude participation at this time and/or require petitioning: Foreign exchange, transfer student, grades, attendance, etc.*)

# ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM
## Part A: Health History Form
**Student Athlete Name**_____ **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? | ☐ | | ☐ | 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 |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | ☐ | Yes | ☐ | No | 26. Have you ever used an inhaler or taken asthma medicine? | ☐ | Yes | ☐ | No |
| 5. Have you ever become dizzy or passed out DURING or AFTER exercise? | ☐ | Yes | ☐ | No | 27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ? | ☐ | Yes | ☐ | No |
| 6. Have you ever had discomfort, pain, or pressure in your chest 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 |
| 7. Do you get more tired than your friends do during exercise? | ☐ | Yes | ☐ | No | 29. Do you have any rashes, pressure sores or other skin problems? | ☐ | Yes | ☐ | No |
| 9. Has a doctor ever told you that you have: ☐High Blood Pressure ☐Heart Murmur ☐Heart Infection ☐High Cholesterol (Check all that apply) | ☐ | Yes | ☐ | No | 30. Have you had a herpes infection? | ☐ | 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 |
| 10. 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 |
| 11. Has anyone in your family ever died for no apparent reason? | ☐ | Yes | ☐ | No | 34. Do you have headaches with exercise? | ☐ | Yes | ☐ | No |
| 12. 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, or legs? | ☐ | Yes | ☐ | No |
| 13. 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 |
| 14. 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 |
| 15. 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 |
| | | | | | 40. Do you wear glasses or contact lenses? | ☐ | Yes | ☐ | No |
| 16. Have you ever spent the night in a hospital? | ☐ | Yes | ☐ | No | 41. Do you wear protective eyewear such as goggles or a face shield? | ☐ | Yes | ☐ | No |
| 17. Have you ever had surgery? | ☐ | Yes | ☐ | No | 42. Are you unhappy with your weight? | ☐ | Yes | ☐ | No |
| 18. 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 affected area below: | | | | | 43. Are you trying to gain or lose weight? | ☐ | Yes | ☐ | No |
| | | | | | 44. Has anyone recommended you change your weight or eating habits? | ☐ | Yes | ☐ | No |
| 19. Have you had any broken or fractured bones or dislocated joints? ☐ Yes ☐ No If yes circle affected area below: | | | | | 45. Do you limit or carefully control what you eat? | ☐ | Yes | ☐ | No |
| 20. 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 affected are below: | | | | | 46. Do you have concerns that you would like to discuss with the doctor/health care provider? | ☐ | Yes | ☐ | No |
| | | | | | FEMALES ONLY: | | | | |
| | | | | | 47. Have you ever 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? _____ | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Head | Neck | Shoulder | Upper arm | Elbow | Calf or shin | Hand | Chest |
| Upper back | Lower Back | Forearm | Thigh | Knee | Hip | Ankle | Feet Toes |

| | | | | |
|---|---|---|---|---|
| 21. Have you ever had a stress fracture? | ☐ | Yes | ☐ | No |
| 22. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability? | ☐ | Yes | ☐ | No |
| 23. 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.):* **DOB:** | **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

Student MAY participate in the following types of sports (CHECK ALL THAT APPLY):
☐ **ALL FORMS OF SPORTS** ☐ CONTACT/COLLISION ☐ NON-CONTACT/STRENUOUS
☐ LIMITED CONTACT ☐ NON-CONTACT/NON-STRENUOUS
☐ STUDENT CLEARED FOR PARTICIPATION
☐ STUDENT CLEARED FOR PARTICIPATION PENDING _____
☐ STUDENT NOT CLEARED FOR PARTICIPATION
Name of Physician/Provider (print/type) _____ Date_____

Signature of Physician /Provider _____

Student's Primary Physician/Provider (for follow up, if necessary):_____