Student-Athlete Name _____ **School ID #** _____ **Grade** _____

School _____ **School Year** _____

Sport(s) Participation: _____

Albuquerque Public Schools Athletic Participation Requirements

Parent(s)/Legal Guardian(s) and Student-Athlete Participating in Athletics:

PLEASE READ THE FOLLOWING STATEMENTS CONCERNING PARTICIPATION IN AN ALBUQUERQUE PUBLIC SCHOOLS (APS) INTERSCHOLASTIC ATHLETIC PROGRAM AND RESPOND WITH YOUR SIGNATURE(S).

Consent to Participate

Consent is hereby given for the named student to engage in interscholastic athletics as approved by APS and represent _____ as a member.
(name of school)

Please list any sports that consent to participate is not given for the above student: _____

Financial Responsibility for Medical Care

It is agreed that 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 pay health care providers for the treatment of any students.

Transportation Responsibilities

It is further agreed that the parent(s)/legal guardian(s) and student will assume the legal responsibilities for the personal safety and action of the above 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. Any exceptions must be arranged with the school prior to departure and in accordance with the athletic travel policy.

Acknowledgement of Injury Risk

We the parent(s)/legal guardian(s) and the student-athlete are aware that preparation for and participation in interscholastic athletics involves a risk of serious and permanent injury to the student-athlete. We understand and acknowledge the danger of these severe injuries as inherent in physical activity.

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. To review the APS established protocol for concussion management, visit the APS athletic website or contact the school athletic trainer for more information.

Notification of Injuries

In order to protect the student-athlete at all times, APS athletic trainers will share information concerning the care, disposition, and treatment of athletic injuries only with the treating physician, team physician, athletic trainer, and coaches on a need to know basis only for the time that the student is in high school. Any information released to third parties by school health providers will be done only with permission of the parent/legal guardian and student.

Physical Examinations

Physical exams are required by the NMAA (6.12) for all athletic, cheer, and dance/drill team participants. The physical exam must be dated April 1 or after 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 during that following school year.

Student-Athlete Name _____ **Student ID #** _____
Last First M.I.

Home Address _____ **Grade** _____
Street City State Zip

Date of Birth _____ **Age:** _____
Month/Day/Year

Authorization for Health Care Services

I/We hereby designate the team coach 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 emergency because of illness or injuries while preparing for or participating 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-athlete. I/We hereby assume all financial responsibility for all health care services provided.

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. **APS does not cover athletic injuries and will not assume the financial responsibility for health care services.**

_____ is covered for accidental/health care insurance through
Student-Athlete Name

☐ APS Health/Accident Insurance carrier:
We have applied for such insurance at _____ on _____
School Date

☐ Private Health/Accident Insurance Carrier _____
(Name of Carrier)

EMERGENCY CONTACT INFORMATION

_____ _____ _____
Student-Athlete Name Date of Birth Age

_____ _____ _____ _____
Parent/ Legal Guardian Name Home Phone Work Phone Cell Phone

_____ _____ _____ _____
Parent/Legal Guardian Name Home Phone Work Phone Cell Phone

_____ _____ _____
Emergency Contact Relationship Phone #

Medication(s) Student-Athlete is Taking: _____

Known Allergies to Medication or Foods: _____

Known Medical Problems: _____

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

_____ _____ _____
Parent/Legal Guardian Signature Date Relationship

_____ _____
Student-Athlete Signature Date

This form should be with coach at all events

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAM FORM

History

(Complete prior to physical exam)

Student Athlete:_____**Age:**_____ **Grade**_____ **Gender** _____

(Please Print) Last First MI

DOB _____**Place of Birth:**_____**Last School Attended** _____

month/day/year City State School

Mailing Address:_____**Home Ph.** _____

Street City St. Zip Code

Name of Parent/Legal Guardian:_____ **Contact Number** _____

Explain "Yes" answers at the end of section

		Yes	No
1	Has a doctor ever denied or restricted your participation in sports for any reason?		
2	Do you have an ongoing medical condition(s) (like asthma or diabetes) ?		
3	Are you currently taking any prescription or non-prescription medications or pills?		
4	Do you have allergies to medicines, pollens, foods, or stinging insects?		
5	Have you ever become dizzy or passed out **during** or a**fter** exercise?		
6	Have you ever had chest discomfort, pain, or pressure during or after exercise?		
7	Do you get more tired than your friends during exercise?		
8	Has a doctor ever told you that you have: (check all that apply)		
	High blood pressure_____Heart murmur _____		
	Heart infection _____High cholesterol_____		
9	Has a doctor ever ordered a test for your heart? (ECG, echocardiogram)		
10	Has anyone in your family ever died for no apparent reason?		
11	Does anyone in your family have a heart condition starting under the age of 50?		
12	Has a family member or relative died of heart problems or sudden death before the age of 50?		
13	Have any of relatives ever had one of the following conditions?		
	Hyptophic cardiomyopathy _____Marfan's syndrome_____		
	Long QT Syndrome _____ Significant heart arrhythmia_____		
14	Have you ever had racing of your heart or skipped a heartbeat?		
15	Have you ever spent the night in a hospital?		
16	Have you ever had surgery? If yes, explain at end of history page.		
17	Have you ever had an injury, such as a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game? If yes, circle below.		
18	Have you had any broken or fractured bones or dislocated joints? If yes, Circle below.		
19	Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, Circle Below		

Circle if 17, 18, or 19 is yes

Head	Shoulder	Upper Arm	Elbow	Hand	
Forearm	Finger	Chest	Upper Back	Lower Back	
Thigh	Hamstring	Knee	Calf	Ankle	Toes

20	Have you ever had a stress fracture?		
21	Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?		
22	Do you regularly use a brace or assistive device?		
23	Has a doctor ever told you that you have asthma or allergies?		
24	Do you cough, wheeze or have difficulty breathing during or after exercise?		
25	Is there anyone in your family with asthma?		
26	Have you ever used an inhaler or taken asthma medicine?		
27	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
28	Have you had a severe viral infection such as infectious mononucleosis(mono) or myocarditis in the last month?		
29	Do you have any rashes, pressure sores, or other skin problems?		
30	Have you had a herpes infection?		
31	Have you had a head injury or concussion?		

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		Yes	No
32	Have you been hit in the head and been confused or lost your memory?		
33	Have you ever had a seizure?		
34	Do you have headaches with exercise?		
35	Have you ever had numbness or tingling or weakness in your arms or legs?		
36	Have you ever been unable to move your arms or legs after being hit or fallen?		
37	When exercising in the heat, do you have severe muscle cramps or become ill?		
38	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
39	Have you had any problems with your eyes or vision?		
40	Do you wear glasses or contacts?		
41	Do you wear protective eyewear such as goggles or a face shield?		
42	Are you unhappy with your weight?		
43	Are you trying to gain or lose weight?		
44	Has anyone recommended you change your weight or eating habits?		
45	Do you limit or carefully control what you eat?		
46	Do you have concerns that you would like to discuss with the doctor/health care provider?		
47	List your last immunizations Tetanus_____(month) ____(year) MMR_____(month) ____(year) Hepatitis Vac_____(month) _____(year)		
	Females Only		
48	Have you ever had a menstrual period?		
49	How old were you when you had your first menstrual period?		
50	How many periods have you had in the last 12 months?		

Maturity Statement for Contact Sports

As a parent you should understand that statistics indicate that there may be an increase in the number of injuries in contact sports for those students who are not of a comparable maturity level as other participants. If you feel that your son/daughter might be subject to potential injury because of his/her stage of development, please discuss this with him/her and your doctor.

Personal Medical Notification

For my own protection I, the student-athlete, agree to inform the athletic trainer/coach at my school and/or all health care providers, BEFORE receiving therapy or treatment of any kind if I am taking any drugs, medication, supplement, or using any ointment, liniments, balms, or have an implant in my body. We the parent(s)/legal guardian(s) and student-athlete understand and acknowledge that any combination of the above and certain therapy may cause serious medical problems to the student-athlete. If the student-athlete is under the care of a licensed health care professional, a written course of treatment must be on file with the school.

Explain "Yes" Answers here:

_____

_____

_____

_____

_____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS VALID AND CORRECT

_____ _____

Student-Athlete Signature **Date**

_____ _____

Parent/ Legal Guardian Signature **Date**

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAM FORM

PHYSICAL EXAMINATION

Student-Athlete Name _____ Gender _____ DOB _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure _____/_____ (____/____:____/____)

Vision R 20/ ____ L 20/ _____ Corrected Y ____ N ____ Pupils: Equal _____ Unequal _____

MEDICAL	**Normal**	**Abnormal**	**Findings/Comments**
Appearance			
(any physical finding of Marfan's syndrome)			
Eyes/Ears/Nose/Throat (if indicated)			
Hearing (if indicated)			

Heart (auscultation should be done supine and standing- abnormal findings require referral for further evaluation)

Murmurs			
Pulses			
Lungs: Auscultation			
Abdomen:			
Genitourinary (only if indicated)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

NOTES: _____

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, Wrestling

☐ NON-CONTACT/STRENUOUS

Baseball, Basketball, Cheerleading, Track/Field (High Jump, Pole Vault) Softball, Volleyball.

☐ LIMITED CONTACT NON-CONTACT/NON-STRENUOUS

Track/Field (Discus, Javelin, Shot Put, Running Events) Cross Country, Dance/Drill, Strength Training, Swimming, Tennis, Bowling, Golf

☐ STUDENT CLEARED FOR PARTICIPATION PENDING (explanation)

☐ STUDENT **NOT** CLEARED FOR PARTICIPATION (explanation)

_____

_____

Name of Physician/Provider _____ ___MD___DO____NP___PA___DC

Signature of Provider _____ **Date:** _____

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

Contact Number _____