

TEXICO MIDDLE SCHOOL AND HIGH SCHOOL INTERSCHOLASTIC PARTICIPATION FORMS

Name _____

Grade _____

PARENTS/GUARDIANS.....Please fill out ALL forms completely and accurately as possible. These forms are required by the New Mexico Activities Association in order for your child to participate in Interscholastic Athletics in New Mexico.

Thank you for your cooperation.

1. Proof of Medical Insurance _____
(PLEASE PROVIDE COPY OF INS. CARD)
2. Emergency Medical Information _____
3. Parental/Guardian Consent _____
4. Medical History _____
5. Physical _____



Texico Wolverines

*****Please turn in completed packet to your coach.***

*****Coaches please check off, sign & date before turning in to the office.)***

Coach's signature _____ Date _____

TEXICO MUNICIPAL SCHOOLS
INTERSCHOLASTIC ATHLETIC PARTICIPATION FORM

Name of Student _____ Date _____ Grade _____

School _____ Date of Birth _____ BirthPlace _____

A. NOTE TO PARENTS

Texico Municipal Schools strive to provide the best possible athletic program for its students. We want athletic participation to be a valuable educational experience at all levels. This form is to be fully completed and on file at the school BEFORE your child will be allowed to practice or compete. We require this physical examination to insure that your child is physically able to participate in athletics and in the event of an accident we may notify you in a relatively short period of time. Please read the following carefully.

B. ACADEMIC ELIGIBILITY

Academic eligibility for participation in extracurricular activities is based on the immediate previous grading period (6 weeks). NMAA mandates require that a participant meet each of the following requirements:

- A. Have passed a minimum of four classes, which are acceptable for graduation credit.
- B. Not have failed more than one course.
- C. Achieved a grade point average of 2.0 or better.

Note #1: A student must be enrolled in at least 4 classes at the time he/she is participating in extracurricular activities.

C. LOSS OF SCHOOL TIME

Parents and students are advised that the New Mexico State Legislature has mandated that a student may not be absent from school for school-sponsored extracurricular activities in excess of 15 days per semester and no class may be missed in excess of 15 times per semester.

D. ACKNOWLEDGEMENT OF INJURY RISKS/INSURANCE/AUTHORIZATION FOR MEDICAL SERVICES

We parent(s)/guardian(s) and student-athletes 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 which may involve vigorous physical contact.

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 New Mexico Activities Association has ruled that all students participating in interscholastic athletics **MUST** be covered under an accident/hospitalization insurance policy. Texico Municipal Schools offer a student accident insurance policy. You may wish to enroll in this through the school. This is strictly On a volunteer basis and is not required if you have sufficient coverage through your own family medical plan.

Texico Municipal Schools may not pay doctors, dentists, or hospitals for any treatment of any child.

We will apply for student accident insurance through Texico Municipal School for the school year 20__ - ____
YES _____ No _____

OR

We have accident insurance through _____
Name of Company

Medicaid # (if applicable) _____

Parent/Guardian Signature _____ Date _____

E. EMERGENCY MEDICAL INFORMATION

I/We request that I/We be contacted within a reasonable time in the event of illness or injury requiring medical service. In the Event we cannot be reached, I/we, parent(s)/guardian(s) hereby designate the Athletic Director, Team Coach, and Athletic Trainer or his /her designee to act in my /our behalf to authorize such hospitalization, medical attention and surgery as may be required in an emergency because of illness or injuries sustained by my/our child/ward while participating in school activities. In the event we cannot be reached, and the situation calls for medical attention, we recognize and relinquish our responsibility to practicing physician and/or medical personnel acting in the best interest of my/our child/ward. I/we here by Assume financial responsibility for hospitalization, medical attention and surgery provided.

Family Physician _____ Phone # _____

Address _____

Family Dentist _____ Phone # _____

Address _____

Hospital _____

Known Allergies _____

Emergency Contact _____ Phone # _____

F. PARENTAL/GUARDIAN CONSENT

We parent(s)/guardian(s) do hereby give our consent for our son/daughter/ward to engage instate association approved Athletic activities as representative of his/her school. We also give our consent for our child/ward to accompany the team, As a member, on its out-of-town trips and in case of an accident release the school and its personnel from liability. We have Completely read, fully understand and voluntarily accept and agree to all of the aforementioned terms and conditions.

Parent/Guardian Signature Business Phone Home Phone

Parent/Guardian Signature Business Phone Home Phone

Student-Athlete Signature Date



**TEXICO MUNICIPAL SCHOOLS
MEDICAL EXAMINATION
FOR PARTICIPATION IN
INTERSCHOLASTIC
ATHLETICS**

New Mexico Activities Association
6600 Palomas NE
Albuquerque, NM 87109
www.nmact.org

NOTE: The NMAA does not need a copy of this form. Please return to your school's athletic department.

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

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

Home Address:

Street City State Zip

Grade:

DOB:

AGE:

Name of Parent/Guardian

Home Address:

Street City State Zip

Phone:

Work:

Cell:

Emergency Contact

Name

Relationship

Phone:

Work:

Cell:

Address:

Street City State Zip

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

Sports/Activities

- | | | | | |
|--|-----------------------------------|--------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Football | <input type="checkbox"/> Cheer/Drill | <input type="checkbox"/> Wrestling | <input type="checkbox"/> Bowling |
| <input type="checkbox"/> Track/Field | <input type="checkbox"/> Tennis | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Golf | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cross country | <input type="checkbox"/> Soccer | <input type="checkbox"/> Softball | <input type="checkbox"/> 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 and return the entire packet to the school's athletic department.

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.

Student-Athlete Signature

Date

Parent or Court Appointed Legal Guardian Signature

Date

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?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	23. Has a doctor ever told you that you have asthma or allergies?		<input type="checkbox"/>		<input type="checkbox"/>	No
2. Do you have an ongoing medical condition (like diabetes or asthma)?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	25. Is there anyone in your family with asthma?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
4. Do you have allergies to medicines, pollens, foods, or stinging insects?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	26. Have you ever used an inhaler or taken asthma medicine?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
5. Have you ever become dizzy or passed out DURING or AFTER exercise?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
6. Have you ever had discomfort, pain, or pressure in your chest during or after exercise?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
7. Do you get more tired than your friends do during exercise?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	29. Do you have any rashes, pressure sores or other skin problems?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
9. Has a doctor ever told you that you have: <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Infection <input type="checkbox"/> High Cholesterol (Check all that apply)		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	30. Have you had a herpes infection?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
						31. Have you had a head injury or concussion?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
						32. Have you been hit in the head and been confused or lost your memory?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
10. Has a doctor ever ordered a test for your heart?(for example ECG, echocardiogram)		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	33. Have you ever had a seizure?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
11. Has anyone in your family ever died for no apparent reason?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	34. Do you have headaches with exercise?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
12. Does any one in your family have a heart problem?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	35. Have you ever had numbness or tingling or weakness in your arms, or legs?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
13. Has a family member or relative died of heart problems or sudden death before the age of 50?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	36. Have you ever been unable to move your arms or legs after being hit or fallen?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	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?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	37. When exercising in the heat, do you have severe muscle cramps or become ill?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
						38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
15. Have you ever had racing of your heart or skipped heartbeats?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	39. Have you had any problems with your eyes or vision?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
16. Have you ever spent the night in a hospital?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	40. Do you wear glasses or contact lenses?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
17. Have you ever had surgery?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	41. Do you wear protective eyewear such as goggles or a face shield?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes circle affected area below:						42. Are you unhappy with your weight?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
19. Have you had any broken or fractured bones or dislocated joints? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes circle affected area below:						43. Are you trying to gain or lose weight?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes circle affected are below:						44. Has anyone recommended you change your weight or eating habits?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
						45. Do you limit or carefully control what you eat?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
						46. Do you have concerns that you would like to discuss with the doctor/health care provider?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
						FEMALES ONLY: 47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> 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? _____					
						Explain "Yes" answers here (use the back of the form if necessary): _____ _____ _____ _____					
Head	Neck	Shoulder	Upper arm	Elbow	Calf or shin	Hand	Chest				
Upper back	Lower Back	Forearm	Thigh	Knee	Hip	Ankle	Foot Toes				
21. Have you ever had a stress fracture?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No						
22. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No						
23. Do you regularly use a brace or assistive device?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No						

TEXICO MUNICIPAL SCHOOLS

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: _____ Blood Pressure: _____/_____/_____
(Per CDC %ile charts) (Recheck if elevated) (per NIH guidelines)
 Blood Pressure %ile _____

Vision: R20/____ L20/____ Corrected: Y / N Pupils : Equal _____ Unequal _____

MEDICAL	Normal (circle one)		Abnormal Findings/Comments
	YES	NO	
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): _____

CLEARANCE FORM

Athlete Name: _____ **Gender** _____ **DOB** _____

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Field Hockey	Baseball	Discus	Bowling
Football	Basketball	Javelin	Golf
Ice Hockey	Cheerleading	Shot put	
Lacrosse	Diving	Rowing	
Soccer	Fencing	Running/Cross Country	
Wrestling	Field	Strength Training	
	High Jump	Swimming	
	Pole vault	Tennis	
	Gymnastics	Track	
	Skiing		
	Softball		
	Volleyball		

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

STUDENT CLEARED FOR 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

STUDENT ATHLETE EMERGENCY INFORMATION

ALLERGIES _____ **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:

Current Medications *(if on asthma medication please indicate if needed prior to sports):*

Does Athlete wear contacts? Yes No **Does Athlete require eye protection while playing?** Yes No

Providers Name		___ MD ___ DO ___ NP ___ PA ___ DC	Phone:
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Address:

<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
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Signature of Provider	Date:
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