# 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: Grade:
*Street City State Zip*

DOB: AGE:

**Name of Parent/Guardian**

Home Address: Phone: Work:
*Street City State Zip* Cell:

**Emergency Contact** Phone: Work:
*Name Relationship* Cell:

Address:
*Street City State Zip*

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

**Sports/Activities**

| | | | | |
|---|---|---|---|---|
| ☐ 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 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? | ☐ | 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:<br>☐High Blood Pressure ☐Heart Murmur<br>☐Heart Infection ☐High Cholesterol<br>(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?<br>☐ 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?<br>☐ 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:<br>47. Have you ever had a menstrual period? ☐Yes ☐No<br>48. How old were you when you had your first menstrual period? ____<br>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 | Foot 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*):**

_____
_____
_____
_____
_____
_____

# 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:** _____ *(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):_____

# 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:** |
| **Address:** | | | |
| *Street* | *City* *State* *Zip* | | |
| **Signature of Provider** | | | **Date:** |

Last updated 5/19/2011