

Name _____

School Year: _____

SPORTS: _____

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

PLEASE READ THE FOLLOWING STATEMENTS CONCERNING PARTICIPATION IN AN ALBUQUERQUE PUBLIC SCHOOL (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 allowed for the above student:_____

Financial Responsibility for Medical Care:

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 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.

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 a 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 for all athletic 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 years will not be valid upon the NMAA starting date for sports during that following school year.

Name _____

School Year _____

Authorization of Health Care Services:

I/We designate the team coach of 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 participation 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 herby assume all financial responsibility for all hearth 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 heath care services.**

_____ is covered for accidental/health care insurance.

Name of student-athlete _____

A **APS Health/Accident Insurance carrier**
 Applied for insurance at _____ on _____
School Date

B **Personnel Health/Accident Insurance Carrier**

(Name of Carrier)

EMERGENCY CONTACT INFORMATION

NAME	DATE OF BIRTH	AGE
PARENT /LEGAL GUARDIAN NAME	HOME PHONE	WORK PHONE
PARENT /LEGAL GUARDIAN NAME	HOME PHONE	CELL PHONE
EMERGENCY CONTACT	RELATIONSHIP	PHONE CONTACT

Medications(s) Student-Athlete is taking: _____

Known allergies to Medication of 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

NAME _____ DATE OF BIRTH _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues

- Do you feel stressed out or under a lot of pressure?
- Do you feel safe at your home or residence?
- During the past 30 days, did you use chewing tobacco, snuff, or dip?
- Have you ever taken anabolic steroids or used any other performance supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- Do you ever feel sad, hopeless, depressed, or anxious?
- Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
- Do you drink alcohol or use any other drugs?
- Do you wear a seat belt, use a helmet, and use condoms?

EXAMINATION

Height _____ Weight _____ BMI _____ Gender- Male Female
 BP _____ / _____ (_____ / _____) Pulse _____ Vision R 20/ _____ L 20/ _____ Corrected Y N Contacts Glasses

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

^a Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^b Consider GU exam if in private setting. Having third party present is recommended.

^c Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Clearance for Participation

Cleared for all sports without restriction

Cleared for all sports without restriction with recommendations for further evaluation or treatment for (Note recommendations): _____

Not cleared Reason: _____

Pending further evaluation _____

For any sports _____

For certain sports _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____



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

Observed by the Parent / Guardian

- | | |
|--|---|
| <ul style="list-style-type: none">• 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” | <ul style="list-style-type: none">• 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

Parent / Guardian

- | | |
|--|--|
| <ul style="list-style-type: none">• TELL YOUR COACH IMMEDIATELY!• Inform Parents• Seek Medical Attention• Give Yourself Time to Recover | <ul style="list-style-type: none">• 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