Albuquerque Public School	Athletic Physical		General Information
Name		School Year:	
SPORTS:			
Parent(s)/Legal Guardina(s) and Studer	nt-Athlete Participation	n in Athletics :	
PLEASE READ THE FOLLOWING STATEMEN (APS) INTERSCHOLASTIC ATHLETIC PROGRA			•
Consent to Participate			
Consent is hereby given for the named stude	ent to engage in interscho as a member.	lastic athletics as appr	oved by APS and represent
Name of school			
Please list any sports that consent to particip	pate is <u>not</u> allowed for the	above student:	
Financial Responsibility for Medical Care:			
Is agreed that financial responsibility for securing the health care provider. APS will not pay health	•	•	rent(s)/legal guardian(s) and

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.

Athletic Physical	Line	rgency Contact/Insuranc
	School Year	
y be recommended in an emerg ery attempt will be made to ma	ency because of illness ke contact with parent	or injuries while preparing (s)/legal guardian(s) prior to
rier contracted through APS at a and will not assume the finance	a nominal rate. Please of ial responsibility for he	contact your school for the
<u> </u>		
		on
<u></u>	School	Date
Health/Accident Insurance Carri	er	
	(Nai	me of Carrier)
DATE OF BIRT	н	AGE
HOME PHONE	WORK PHONE	CELL PHONE
		<u> </u>
HOME PHONE	WORK PHONE	CELL PHONE
RELATIONSHIP	PHONE CONTACT	PHONE CONTACT
	ee to act in my/our behalf to aut y be recommended in an emerg ery attempt will be made to mal onging care for the student-athl ior to tryout, practice, or particip rier contracted through APS at a and will not assume the finance is covered for accidental/h /Accident Insurance carrier plied for insurance at Health/Accident Insurance Carri DATE OF BIRTI HOME PHONE HOME PHONE RELATIONSHIP	see to act in my/our behalf to authorize such hospitalizary be recommended in an emergency because of illness ery attempt will be made to make contact with parent onging care for the student-athlete. I/We herby assume the student-athlete. I/We herby assume the trier contracted through APS at a nominal rate. Please of and will not assume the financial responsibility for here is covered for accidental/health care insurance. //Accident Insurance carrier school Health/Accident Insurance Carrier DATE OF BIRTH

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	

Albuquerque Public Schools

HISTORY FORM

NameCradeCr			Date of Birth		
Gender Age Grade Sch Medicines and Allergies: Please list all of the prescription and over	ool er-the	-counter	Sport(s) medicines and supplements (herbal and nutritional) that you are current	ly takin	
The distribution of the prescription and of		Counter	medicines and supplements (nersulation and national) that you are current	ry caran	
Do you have any allergies?	dentify	specific a	illergy below.		
Medicines Pollens	<i></i>		Food Stinging Insects		
Explain "Yes" answers below. Circle questions you don't know ENERAL QUESTIONS	the ans	wers to.	Medical Questions	Yes	No
Has a doctor ever denied your participation in sports for any reason?	163	NO	26. Do you cough, wheeze, or have difficulty breathing during or after	163	140
Do you have any ongoing medical conditions? If so, please identify			exercise?		
low: 🗖 Asthma 🗖 Anemia 🗖 Diabetes 🗖 Infections her:			Nave you ever used an inhaler or taken asthma medicine? Is there anyone in your family who has asthma?		
Have you ever spent the night in the hospital?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
Have you ever had surgery? EART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area		+
Have you ever passed out or nearly passed out DURING or AFTER	163	NO	31. Have you had infectious mononucleosis (mono) within the last month?		†
sercise?			32. Do you have any rashes, pressure sores, or other skin problems?		1
Have you ever had discomfort, pain, tightness, or pressure in your chest			33. Have you had herpes or MRSA skin infection?		
uring exercise?			34. Have you ever had a head injury or concussion?		Д
Does your heart ever race or skip beats (irregular beats) during exercise?	-	 	35. Have you ever had a hit or blow to the head that caused confusion,		
Has a doctor ever told you that you have any heart problems? If so, eck all that apply:			prolonged headache, or memory problems? 36. Do you have a history of seizure disorder?		+
High Blood Pressure			37. Do you have headaches with exercise?		+
High Cholesterol A heart infection			38. Have you ever had numbness, tingling, or weakness in your arms or		+
Kawasaki Disease Other:			legs after being hit or falling?		
Has a doctor ever ordered a test for your heart? (For example:			39. Have you ever been unable to move your arms or legs after being hit or		
G/EKG, echocardiogram)			falling?		4
. Do you get lightheaded or feel more short of breath than expected			40. Have you ever become ill while exercising in the heat? 41. Do you get frequent muscle cramps when exercising?		+
iring exercise?			42. Do you or someone in your family have sickle cell trait or disease?		+-
Have you ever had an unexplained seizure?			43. Have you had any problems with your eyes or vision?		†
I. Do you get more tired or short of breath more quickly than your ends during exercise?			44. Have you had any eye injuries?		
EART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?		
. Has any family member or relative died of heart problems or had an			46. Do you wear protective eyewear, such as goggles or a face shield?		—
nexpected or unexplained sudden death before age 50 (including			47. Do you worry about your weight?		+-
owning, unexplained car accident or sudden infant death syndrome)?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
I. Does anyone in your family have hypertrophic cardiomyopathy, Marfan ndrome, arrhythmogenic right ventricular cardiomyopathy, long QT			49. Are you on a special diet or do you avoid certain types of foods?		+
ndrome, short QT syndrome, Brugada syndrome, or catecholaminergic			50. Have you ever had an eating disorder?		1
olymorphic ventricular tachycardia?			51. Do you have any concerns that you would like to discuss with a doctor?		
5. Does anyone in your family have a heart problem, pacemaker or					
pplanted defibrillator?			FEMALES ONLY	Yes	No
5. Has anyone in your family had unexplained fainting, unexplained			52. Have you ever had a menstrual period?		+
cizures or near drowning? ONE AND JOINT QUESTIONS	Yes	No	53. How old were you when you had your first menstrual period? 54. How many periods have you had in the last 12 months?		+-
7. Have you ever had an injury to a bone, muscle, ligament or tendon that			2 many periods have you not in the last 12 months.		+-
used you to miss practice or a game?					
3. Have you ever had any broken or fractured bones or dislocated joints?					
). Have you ever had an injury that required x-rays, MRI, CT scan,			Explain "Yes" answers here		
jections, therapy, a brace, a cast or crutches? D. Have you ever had a stress fracture?					
L. Have you ever had a stress fracture:					
eck instability or atlantoaxial instability? (Down syndrome or dwarfism)					
2. Do you regularly use a brace, orthotics, or other assistive device?					
B. Do you have bone muscle or joint injury that bothers you?					
I. Do any of your joints become painful, swollen, feel warm or look red?					
. Do you have any history of juvenile arthritis or connective tissue sease?					
I hereby state that to, the best of my knowledge, my ans	wers	to the al	pove questions are complete and correct.		

Adapted from 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society of Sports Medicine, and American Osteopathic Academy of Sports Medicine.

Albuquerque Public School	PHYSICAL EXAMINATION FORM		
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 perform	 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 BMI Gender- Male	e Female		
BP/() PulseVision 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。 • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only)₀			
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			
Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion. Clearance for Participation	B Consider GU exam if in private setting. Having third party present is recommended.		
Cleared for all sports without restriction Cleared for all sports without restriction with recommendations for further evaluations.	aluation or treatment for(Note recommendations):		
Not cleared Reason: Pending further evaluation For any sports For certain sports			
nave examined the above-named student and completed the preparticipation physical evaluation articipate in the sport(s) as outlined above if conditions arise after the athlete has been cleared for and the potential consequences are completely explained to the athlete (and parents/guardians).			
ame of physician (print/type)	Date		

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Address

Signature of physician _

_ Phone _



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

- 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"

Observed by the Parent / Guardian

- 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

- TELL YOUR COACH IMMEDIATELY!
- Inform Parents
- Seek Medical Attention
- Give Yourself Time to Recover

Parent / Guardian

- 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

<u> SIGNATURES</u>		
Concussion in Sports Fact Sh	neet for Athletes and Pare ociated with participation	and reviewed the attached NMAA's ents. I also acknowledge and I understand in in school athletic activity, and I am cussion Law.
Athlete's Signature	Print Name	Date
Parent/Guardian's Signature	Print Name	Date