Nombre del estudiante atleta ___________________________ No. de identif.: ___________ Grado _____
Escuela ____ Año escolar ______________
Deporte(s) en el(los) que participa ____

Requisitos de las Escuelas Públicas de Albuquerque para participar en deportes

Para: Padres o tutores del estudiante atleta que participa en deportes

SÍRVASE LEER LAS INDICACIONES QUE SE DAN A CONTINUACIÓN CON RESPECTO A LA PARTICIPACIÓN EN LAS ACTIVIDADES DEPORTIVAS INTERESCOLARES DE APS Y CONTESTE(N) MEDIANTE SU(S) FIRMA(S).

<u>Consentimiento para participar</u>

Por este medio se da consentimiento para que el estudiante cuyo nombre aparece arriba participe en actividades deportivas interescolares sancionadas por APS y para representar a la escuela ____________________________________ como integrante de un equipo escolar.

Favor de indicar los deportes para los que no se le da consentimiento para participar: ____________________

<u>Responsabilidad financiera para la atención médica</u>

Se acepta que la responsabilidad financiera por la atención médica obtenida cuando el estudiante haya sufrido una lesión durante la práctica de un deporte es un asunto entre el padre o tutor y el prestatario de servicios médicos y que APS no puede pagarles a éstos por el tratamiento que le brinden.

<u>Responsabilidad de transportación</u>

Se acepta, además, que el padre o el tutor y el estudiante asumirán todas las responsabilidades legales por la seguridad personal y las acciones de dicho estudiante mientras esté en el trayecto hacia las prácticas y los encuentros deportivos y de regreso de ellos cuando APS no esté proporcionando el transporte. Cuando el transporte sea proporcionado por APS, se les exige a los estudiantes que viajen en el autobús de APS de ida y venida. Cualquier excepción se arreglará con la escuela antes del viaje y de acuerdo con las normas de transporte del departamento de deportes.

<u>Admisión del riesgo de lesionarse</u>

Los padres o tutores y el estudiante deportista admitimos que la preparación para participar en actividades deportivas interescolares y la participación en ellas presenta muchos riesgos de sufrir lesiones graves y permanentes. Comprendemos y reconocemos el peligro que representan las lesiones graves inherentes a la actividad física.

<u>Manejo de una conmoción cerebral</u>

Una conmoción cerebral es una interrupción de la función del cerebro que puede ser causada por un golpe al cuerpo o a la cabeza, y puede ocurrir en cualquier deporte o actividad. Los efectos de una conmoción pueden manifestarse en una variedad de síntomas (dolor de cabeza, nausea, mareo, pérdida de la memoria, problemas de equilibrio) con o sin la pérdida del conocimiento.
Quedo informado (quedamos informados) que se ha establecido un protocolo en cuanto al manejo de una conmoción cerebral el cual señala los criterios para recibir atención médica y para regresar a jugar. Si desea revisar el protocolo que APS ha establecido sobre el manejo de una conmoción, puede visitar el sitio web de atletismo de APS o si desea mayor información, puede comunicarse con el entrenador de deportes de la escuela.

<u>Notificación en caso de lesionarse</u>

Para poder proteger en todo momento al estudiante deportista, los entrenadores de APS compartirán información del estudiante en cuanto al cuidado médico, disposición y tratamiento de lesiones causadas por el deporte solamente con el doctor que lo atiende, el médico del equipo y los entrenadores sólo cuando sea absolutamente necesario compartir dicha información mientras el estudiante estén en la escuela secundaria superior. Toda información que se divulgue a terceras partes se hará solamente con el permiso de los padres y estudiantes.

<u>Exámenes físicos</u>

La organización NMAA (~~4.16~~) exige que todos los atletas, porristas y participantes de equipos de ejercicios tengan un examen físico. Dicho examen deberá llevarse a cabo el 1º de abril o después para que sea válido durante el siguiente año escolar. Los exámenes físicos realizados antes del 1º de abril del año que cursa no serán válidos al iniciarse la temporada de deportes de la NMAA del año escolar subsecuente.

Nombre del estudiante atleta ____ **No. de identif.** __________

Apellido　　　　Primer nombre　　　　Inicial del 2º nombre

Domicilio ____ **Grado** ______

Calle　　　　Ciudad　　　　Estado　　　　Código postal

Fecha de nacimiento ________________________________ **Edad** ____________

Mes / día / año

Autorización para obtener atención médica

Yo/Nosotros designo/designamos al entrenador del equipo deportivo o a la persona que él designe para que, actuando en mi nombre, autorice la hospitalización, atención médica, cirugía y cualesquiera otros servicios médicos que se recomienden en una situación de urgencia debido a la enfermedad o a las lesiones que este estudiante haya sufrido mientras se esté preparando para participar en actividades deportivas interescolares o mientras estuviese participando en ellas. Se hará todo lo posible para contactar a los padres o tutores antes de tomar cualquier decisión, de ser posible sin tener que prolongar la atención médica para el estudiante atleta. Yo/Nosotros asumo/asumimos toda la responsabilidad financiera por toda la atención médica que se le brinde al estudiante.

Seguro médico y contra accidentes:

Se requiere que el estudiante tenga seguro médico y contra accidentes antes de que se le permita presentarse a las pruebas para practicar un deporte, acudir a las prácticas o participar en actividades deportivas interescolares. El seguro se puede adquirir de una empresa particular o de una que esté bajo contrato con APS a una tarifa nominal. La escuela le podrá proporcionar la debida solicitud. **APS no responsabiliza por las lesiones que puedan ocurrir por participar en un deporte.**

____ tiene seguro médico y contra accidentes a través de:

Nombre del estudiante atleta

_____ Seguro médico y contra accidentes a través de APS
Hemos solicitado seguro médico y contra accidentes en ____________________________ el ________________

Escuela　　　　Fecha

_____ Seguro médico y contra accidentes a través de la aseguradora particular ________________________________

Nombre de la aseguradora

INFORMACIÓN SOBRE PERSONAS CONTACTO EN CASO DE UNA EMERGENCIA

Nombre del estudiante atleta	Fecha de nacimiento		Edad
Nombre del padre o tutor	Tel. de casa	Tel. del trabajo	Tel. celular
Nombre del padre o tutor	Tel. de casa	Tel. del trabajo	Tel. celular
Contacto en caso de emergencia	Parentesco		Teléfono

Medicamentos que el estudiante atleta toma ____

____

Alergias conocidas a medicamentos o comida ____

____

Problemas médicos conocidos ____

____

Los padres o tutores y el estudiante deportista han leído y comprendido completamente y voluntariamente aceptan y están de acuerdo con todos los términos y condiciones arriba mencionados (p. 1 y p. 2). También verificamos que toda la información que proporcionamos es correcta.

Firma del padre o tutor　　　　Fecha　　　　Parentesco

Firma del estudiante deportista　　　　Fecha

El entrenador deberá de tener consigo esta hoja durante todos los eventos.

Albuquerque Public Schools

HISTORY FORM

(Note: This form is to be filled out by the student-athlete and parent prior to seeing the physician.)

Name____ Date of Birth____________________

Gender_________ Age__________ Grade__________ School______________________________ Sport(s) ____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

____

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High Blood Pressure ☐ A heart murmur ☐ High Cholesterol ☐ A heart infection ☐ Kawasaki Disease Other: __________________________		
9. Has a doctor ever ordered a test for your heart? (For example: ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have bone muscle or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

Medical Questions	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "Yes" answers here

____

____

____

____

____

I hereby state that to, the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete____**Signature of parent/guardian**____**Date**______________

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.

Aug 2012

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 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 ______________________________

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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

- 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

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