



# Athletics Parental Consent Form 2017-2018

Name of Student \_\_\_\_\_

Grade for 2017-2018 \_\_\_\_\_

This form includes:

- A. Parental consent for participation in athletics
- B. Authorization for medical services
- C. Personal medication notification by student
- D. Insurance coverage
- E. Physician's Statement (Physical Examination Form)
- F. Acknowledgement of basic eligibility standards
- G. Acknowledgement of injury risks
- H. Concussion in Sports Fact Sheet for Athletes and Parents

**Parent/Guardian,**

Please read the following statements concerning the participation of your child(ren) in interscholastic athletics and provide the requested information. The West Las Vegas School District provides the best possible athletic programs for its students. The District strives to make athletic participation a valuable educational experience at all levels. Discuss these contents with your child, complete it fully, and have your physician sign following the physical exam. This form must be completed for any student who intends to participate in interscholastic athletics at any level prior to active participation.

**Parent Consent**

I/we hereby give my/our consent for \_\_\_\_\_ to participate in interscholastic athletics within the **West Las Vegas School District** and authorize said district to provide the information on this form to the New Mexico Activities Association. 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 school may not pay doctors, dentists, or hospitals for any treatment of any child.

**Acknowledgement of Injury Risk**

We are aware that preparation for and participation in interscholastic athletics involves risk of serious and permanent injury to the student-athlete. We acknowledge and understand the danger of possible severe injuries inherent in physical activity and contact in all sports.

**Insurance**

I/we have secured health/accident insurance which I consider sufficient to cover expenses/claims arising from any injury my child may experience while participating on any athletic team, and will not hold the WLVS District responsible for payment of any medical expenses.

Insurance Co \_\_\_\_\_ Policy \_\_\_\_\_

*\* A COPY OF YOUR INSURANCE CARD MUST BE INCLUDED WITH THIS PHYSICAL.*

**Medical History**

I/we hereby state that I/we have reviewed the medical history of my/our child and find the answers to the questions correct to the best of my/our knowledge. (Required for legal minors.)

**Authorization for Medical Services**

I/we request that I/we be contracted within a reasonable time in the event of illness or injury requiring medical services. In the event I/we cannot be reached, I/we, hereby authorize the appropriate school representative to act in my behalf to ensure proper medical attention as may be required due to injury or illness sustained by my child while participating in school athletics. If I cannot be reached, I relinquish my responsibility to medical personnel acting in the best interest of my child. I assure financial responsibility for such attention.

**Student Statements**

I will abide by the rules set up by the coach and by all rules contained in the school’s **Student Handbook, Athletic Handbook and NMAA Bylaws**. I assume full responsibility for the athletic equipment and uniforms issued to me. I will inform the coach/trainer/medical personnel if I am taking medication, using any ointment, liniment, balm, or have a metal implant in my body *before* receiving therapy or treatment of any kind in the training room.

Are you taking any medication(s)? Identify \_\_\_\_\_  
Are you allergic to any medications(s)? Identify \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Street City Zip

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Street City Zip

Hospital Preference \_\_\_\_\_

Parent and Emergency Contact Phone Numbers \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian & Date

\_\_\_\_\_  
Signature of Parent/Guardian & Date

\_\_\_\_\_  
Signature of Student-Athlete & Date



# MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

(Cover sheet)

New Mexico Activities Association  
6600 Palomas NE  
Albuquerque, NM 87109  
[www.nmact.org](http://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.

<b>Student Athlete Name</b> ( <i>Last, First, M.I.</i> ):				
Home Address:			Grade:	
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>	
DOB:			AGE:	
<b>Name of Parent/Guardian</b>				
Home Address:			Phone:	Work:
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>	Cell:
<b>Emergency Contact</b>			Phone:	Work:
<i>Name</i>		<i>Relationship</i>		Cell:
Address:				
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>	

## 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

# PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ 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 or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> 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 a 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 a 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 a 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		
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 \_\_\_\_\_

# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

## PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - 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 wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ ( _____ / _____ )	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
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 <sup>a</sup> • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) <sup>b</sup>		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic <sup>c</sup>		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.

<sup>c</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_

- Not cleared
- Pending further evaluation
- For any sports
- For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

**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. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. 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 \_\_\_\_\_, MD or DO



# NMAA

New Mexico Activities Association

## CONCUSSION IN SPORTS

## A Fact Sheet for Athletes and Parents

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### 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.

Students need cognitive rest from the classroom, texting, cell phones, etc.

## **REFERENCES ON SENATE BILL 1 AND BRAIN INJURIES**

Senate Bill 1:

<http://www.nmlegis.gov/Sessions/10%20Regular/final/SB0001.pdf>

For more information on brain injuries check the following websites:

<http://www.nfhs.org/resources/sports-medicine>

<http://www.cdc.gov/concussion/HeadsUp/youth.html>

<http://www.stopsportsinjuries.org/concussion.aspx>

<http://www.ncaa.org/health-and-safety/medical-conditions/concussions>



## **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 the New Mexico's Senate Bill 1; Concussion Law.

\_\_\_\_\_  
Athlete's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date