Student-Athlete Name _____ School ID # _____ Grade _____

School _____ School Year _____

Sport(s) Participation: _____

## Amy Biehl High School Athletic Participation Requirements

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

**PLEASE READ THE FOLLOWING STATEMENTS CONCERNING PARTICIPATION IN AN Amy Biehl High School 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 ABHS and represent _____ as a member.
(name of school)

Please list any sports that consent to participate is not given for the above student: _____

### Financial Responsibility for Medical Care

It 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. ABHS 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 ABHS. When transportation is provided by ABHS, 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 a 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.

### Notification of Injuries

In order to protect the student-athlete at all times, ABHS 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 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, cheer, and dance/drill team 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 year will not be valid upon the NMAA starting date for sports during that following school year.

Student-Athlete Name _____ Student ID # _____
Last First M.I

Home Address _____ Grade _____
Street City State Zip

Date of Birth _____ Age: _____
Month/Day/Year

## Authorization for Health Care Services

I/We hereby designate the team coach or 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 participating 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 hereby assume all financial responsibility for all health care services provided.

### Accidental/Health Care Insurance:

**Accidental/Health Insurance is a requirement, prior to tryout, practice, or participation in interscholastic athletics.**

**AAU does not cover athletic injuries and will not assume the financial responsibility for health care services.**

_____ is covered for accidental/health care insurance through
Student-Athlete Name

☐ Private Health/Accident Insurance Carrier _____
(Name of Carrier)

## EMERGENCY CONTACT INFORMATION

Student-Athlete Name _____ Date of Birth _____ Age _____

Parent/ Legal Guardian Name _____ Home Phone _____ Work Phone _____ Cell Phone _____

Parent/Legal Guardian Name _____ Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact _____ Relationship _____ Phone # _____

Medication(s) Student-Athlete is Taking: _____

Known Allergies to Medication or 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 _____

**This form should be with coach at all events**

# ATHLETIC PRE-PARTICIPATION PHYSICAL EXAM FORM

**History**

(Complete prior to physical exam)

Student Athlete:_____ Age:_____ Grade_____ Gender _____
(Please Print) Last First MI

DOB _____ Place of Birth:_____ Last School Attended _____
month/day/year City State School

Mailing Address:_____ Home Ph. _____
Street City St Zip Code

Name of Parent/Legal Guardian:_____ Contact Number _____

## Explain "Yes" answers at the end of section

| | | Yes | No |
|---|---|---|---|
| 1 | Has a doctor ever denied or restricted your participation in sports for any reason? | | |
| 2 | Do you have an ongoing medical condition(s) (like asthma or diabetes) ? | | |
| 3 | Are you currently taking any prescription or non-prescription medications or pills? | | |
| 4 | Do you have allergies to medicines, pollens, foods, or stinging insects? | | |
| 5 | Have you ever become dizzy or passed out during or after exercise? | | |
| 6 | Have you ever had chest discomfort, pain, or pressure during or after exercise? | | |
| 7 | Do you get more tired than your friends during exercise? | | |
| 8 | Has a doctor ever told you that you have. (check all that apply) | | |
| | High blood pressure_____ Heart murmur _____ | | |
| | Heart infection _____ High cholesterol_____ | | |
| 9 | Has a doctor ever ordered a test for your heart? (ECG, echocardiogram) | | |
| 10 | Has anyone in your family ever died for no apparent reason? | | |
| 11 | Does anyone in your family have a heart condition starting under the age of 50? | | |
| 12 | Has a family member or relative died of heart problems or sudden death before the age of 50? | | |
| 13 | Have any of relatives ever had one of the following conditions? | | |
| | Hyptophic cardiomyopathy _____ Marfan's syndrome_____ | | |
| | Long QT Syndrome _____ Significant heart arrhythmia_____ | | |
| 14 | Have you ever had racing of your heart or skipped a heartbeat? | | |
| 15 | Have you ever spent the night in a hospital? | | |
| 16 | Have you ever had surgery? If yes, explain at end of history page. | | |
| 17 | Have you ever had an injury, such as a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game? If yes, circle below. | | |
| 18 | Have you had any broken or fractured bones or dislocated joints? If yes, Circle below. | | |
| 19 | Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, Circle Below | | |

**Circle if 17, 18, or 19 is yes**

| | | | | | |
|---|---|---|---|---|---|
| Head | Shoulder | Upper Arm | Elbow | Hand | |
| Forearm | Finger | Chest | Upper Back | Lower Back | |
| Thigh | Hamstring | Knee | Calf | Ankle | Toes |

| | | | |
|---|---|---|---|
| 20 | Have you ever had a stress fracture? | | |
| 21 | Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability? | | |
| 22 | Do you regularly use a brace or assistive device? | | |
| 23 | Has a doctor ever told you that you have asthma or allergies? | | |
| 24 | Do you cough, wheeze or have difficulty breathing during or after exercise? | | |
| 25 | Is there anyone in your family with asthma? | | |
| 26 | Have you ever used an inhaler or taken asthma medicine? | | |
| 27 | Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | | |
| 28 | Have you had a severe viral infection such as infectious mononucleosis(mono) or myocarditis in the last month? | | |
| 29 | Do you have any rashes, pressure sores, or other skin problems? | | |
| 30 | Have you had a herpes infection? | | |
| 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? | | |
| 33 | Have you ever had a seizure? | | |
| 34 | Do you have headaches with exercise? | | |
| 35 | Have you ever had numbness or tingling or weakness in your arms or legs? | | |
| 36 | Have you ever been unable to move your arms or legs after being hit or fallen? | | |
| 37 | When exercising in the heat, do you have severe muscle cramps or become ill? | | |
| 38 | Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | | |
| 39 | Have you had any problems with your eyes or vision? | | |
| 40 | Do you wear glasses or contacts? | | |
| 41 | Do you wear protective eyewear such as goggles or a face shield? | | |
| 42 | Are you unhappy with your weight? | | |
| 43 | Are you trying to gain or lose weight? | | |
| 44 | Has anyone recommended you change your weight or eating habits? | | |
| 45 | Do you limit or carefully control what you eat? | | |
| 46 | Do you have concerns that you would like to discuss with the doctor/health care provider? | | |
| 47 | List your last immunizations | | |
| | Tetanus_____(month) _____(year) MMR_____(month) _____(year) Hepatitis Vac_____(month) _____(year) | | |
| | **Females Only** | | |
| 48 | Have you ever had a menstrual period? | | |
| 49 | How old were you when you had your first menstrual period? | | |
| 50 | How many periods have you had in the last 12 months? | | |

### Maturity Statement for Contact Sports

As a parent you should understand that statistics indicate that there may be an increase in the number of injuries in contact sports for those students who are not of a comparable maturity level as other participants. If you feel that your son/daughter might be subject to potential injury because of his/her stage of development, please discuss this with him/her and your doctor.

### Personal Medical Notification

For my own protection I, the student-athlete, agree to inform the athletic trainer/coach at my school and/or all health care providers, BEFORE receiving therapy or treatment of any kind if I am taking any drugs, medication, supplement, or using any ointment, liniments, balms, or have an implant in my body. We the parent(s)/legal guardian(s) and student-athlete understand and acknowledge that any combination of the above and certain therapy may cause serious medical problems to the student-athlete. If the student-athlete is under the care of a licensed health care professional, a written course of treatment must be on file with the school.

### Explain "Yes" Answers here:

_____

_____

_____

_____

_____

### I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS VALID AND CORRECT

_____ _____

**Student-Athlete Signature** **Date**

_____ _____

**Parent/ Legal Guardian Signature** **Date**

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAM FORM

**PHYSICAL EXAMINATION**

Student-Athlete Name _____ Gender _____ DOB _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure _____ / _____ ( _____ / _____ : _____ / _____ )

Vision R 20/ ____ L 20/ ____ Corrected Y ____ N ____ Pupils: Equal _____ Unequal _____

| MEDICAL | Normal | Abnormal | Findings/Comments |
|---|---|---|---|
| Appearance | | | |
| (any physical finding of Marfan's syndrome) | | | |
| Eyes/Ears/Nose/Throat (if indicated) | | | |
| Hearing (if indicated) | | | |
| **Heart** (auscultation should be done supine and standing- abnormal findings require referral for further evaluation) | | | |
| Murmurs | | | |
| Pulses | | | |
| Lungs: Auscultation | | | |
| Abdomen: | | | |
| Genitourinary (only if indicated) | | | |
| Skin | | | |
| **MUSCULOSKELETAL** | | | |
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand/Fingers | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot/Toes | | | |

NOTES: _____

I verify that I have reviewed the Medical History information provided and after exam clear student for the following:

**Student-Athlete MAY participate in the following types of sports (CHECK ALL THAT APPLY):**

☐ ALL FORMS OF SPORTS/ACTIVITIES

☐ CONTACT/COLLISION
Football , Soccer, Wrestling

☐ NON-CONTACT/STRENUOUS
Baseball, Basketball, Cheerleading, Track/Field (High Jump, Pole Vault) Softball, Volleyball

☐ LIMITED CONTACT NON-CONTACT/NON-STRENUOUS
Track/Field (Discus, Javelin, Shot Put, Running Events) Cross Country, Dance/Drill, Strength Training Swimming Tennis, Bowling Golf

☐ STUDENT CLEARED FOR PARTICIPATION PENDING (explanation)

☐ STUDENT NOT CLEARED FOR PARTICIPATION (explanation)

_____

_____

**Name of Physician/Provider** _____ ___MD___DO___NP___PA___DC

**Signature of Provider** _____ **Date:** _____

Student's Primary Physician/Provider (for follow up if necessary): _____

Contact Number _____

# 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 |