

**Student's Name** \_\_\_\_\_ **ID Number** \_\_\_\_\_  
**Birth Date:** \_\_\_\_\_ **School Year** \_\_\_\_\_ **Grade** \_\_\_\_\_  
**Sport(s) Participating:** \_\_\_\_\_  
**Emergency Contact:** \_\_\_\_\_ **Number:** \_\_\_\_\_  
**Medication:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

### **Albuquerque Public Schools Athletic Participation Requirements**

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

**PLEASE READ THE FOLLOWING STATEMENTS CONCERNING PARTICIPATION IN ALBUQUERQUE PUBLIC SCHOOLS (APS) INTERSCHOLASTIC ATHLETICS 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)

It is agreed that financial responsibility for securing care of athletic injuries is a matter between the parent(s)/guardian(s) and the health care provider. APS cannot pay health care providers for treatment of any students.

It is further agreed that the parent(s)/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 to travel to and from on that bus. 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)/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.**

#### **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)/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 is under the care of a licensed health care professional, a written course of treatment must be on file with the school.

#### **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 third parties will be done only with permission of the parents and students.

#### **Physical Examinations**

Physical exams are required by NMAA 6.12 for all athletic, cheer, and drill participants. The physical must be dated April 1st or after to be valid for the following school 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. I/We hereby assume all financial responsibility for all health care services provided.

**Accidental/Health 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.**

**Please check and complete each that applies:**

\_\_\_\_ APS Health/Accidental Insurance carrier:  
We have applied for accidental/health insurance at \_\_\_\_\_  
(Name of School)

\_\_\_\_ Private Health/Accident Insurance Carrier \_\_\_\_\_  
(Name of Company)

**EMERGENCY CONTACT INFORMATION**

\_\_\_\_\_  
Student Name Date of Birth

\_\_\_\_\_  
Parent/Guardian Name Home Phone # Parent Work Phone #

\_\_\_\_\_  
Parent/Guardian Name Home Phone # Parent Work Phone #

\_\_\_\_\_  
Emergency Contact Relationship Phone #

Medication(s) Student is taking: \_\_\_\_\_

Known Allergies to Medication or Foods: \_\_\_\_\_

Known Medical Problems: \_\_\_\_\_

**We the parent(s)/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 also verify all information provided is correct.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Relationship (Print)

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Date

(This page should be with the coach on all out of district trips)

## Pre-Participation Medical History Evaluation

Student Name \_\_\_\_\_ ID \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_

City/State of Birth \_\_\_\_\_ School Last Year \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Personal Physician \_\_\_\_\_ Physician's Phone # \_\_\_\_\_

Dentist Name \_\_\_\_\_ Dentist Phone # \_\_\_\_\_

**Explain all "YES" answers on reverse side**

**YES NO**

- |     |  |       |       |
|-----|--|-------|-------|
| 1.  | Are you under a physician's care for any reason now?                                       | _____ | _____ |
|     | Have you ever been hospitalized?   | _____ | _____ |
|     | Have you ever had surgery (i.e. tonsillectomy, arthroscopy, etc.)?                         | _____ | _____ |
|     | Are you missing any organs?  | _____ | _____ |
| 2.  | Are you presently taking any medications or pills?   | _____ | _____ |
| 3.  | Do you have any allergies (hay fever, hives, eczema, medicines, stinging insects, etc.)?   | _____ | _____ |
| 4.  | Do you have asthma or do you have trouble breathing or cough during or after activity?     | _____ | _____ |
| 5.  | Have you ever passed out during or after exercise?   | _____ | _____ |
|     | Have you ever been dizzy during or after exercise?   | _____ | _____ |
|     | Have you ever had chest pain during or after exercise?                                     | _____ | _____ |
|     | Do you tire more quickly than your friends during exercise?                                | _____ | _____ |
|     | Have you ever had high blood pressure?   | _____ | _____ |
|     | Have you ever been told that you have a heart murmur?                                      | _____ | _____ |
|     | Have you ever had racing of you heart or skipped beats?                                    | _____ | _____ |
|     | Has anyone in your family experiences or died of heart problems before age 50?             | _____ | _____ |
| 6.  | Do you have, or have you had in the last six months, skin rashes?                          | _____ | _____ |
| 7.  | Have you had a head injury?  | _____ | _____ |
|     | Have you ever been knocked out unconscious?  | _____ | _____ |
|     | Have you ever had a memory loss from any cause?  | _____ | _____ |
|     | Have you ever had a seizure?   | _____ | _____ |
|     | Have you ever had a stinger or burner or pinched nerve in the neck?                        | _____ | _____ |
| 8.  | Have you ever had heat cramps or muscle cramps?  | _____ | _____ |
|     | Have you ever been dizzy or passed out in the heat?  | _____ | _____ |
| 9.  | Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards etc.)? | _____ | _____ |
| 10. | Have you had any problems with eyes or vision?   | _____ | _____ |
|     | Do you wear glasses or contacts or protective eyewear?                                     | _____ | _____ |

**Pre-Participation Medical History Evaluation (continued)**

- 11. Do you wear any dental appliances (braces, false teeth)? \_\_\_\_\_
- 12. Do you have any ear drum tubes or a perforated eardrum? \_\_\_\_\_
- 13. Have you ever missed practice for three (3) or more days? \_\_\_\_\_
- 14. Have you had any medical problems (i.e. infectious mononucleosis, diabetes, etc)? \_\_\_\_\_
- 15. Have you had any medical problems or injury since your last physical evaluation? \_\_\_\_\_
- 16. Have you ever been told not to participate in any sport? \_\_\_\_\_  
If yes, which sport and when? \_\_\_\_\_
- 17. When was your last tetanus (Td) shot? \_\_\_\_\_(month)\_\_\_\_\_ (year)
- 18. When was your last measles (MMR) immunization? \_\_\_\_\_(month)\_\_\_\_\_ (year)
- 19. Check any of the following you have sprained or strained, dislocated, broken or had repeated swelling of:  
\_\_\_\_\_Hand \_\_\_\_\_Neck \_\_\_\_\_Chest \_\_\_\_\_Back \_\_\_\_\_Shoulder  
\_\_\_\_\_Elbow \_\_\_\_\_Forearm \_\_\_\_\_Wrist \_\_\_\_\_Hand \_\_\_\_\_Hip  
\_\_\_\_\_Thigh \_\_\_\_\_Knee \_\_\_\_\_Ankle \_\_\_\_\_Foot \_\_\_\_\_Shin/Calf

**Question #20 for females only:**

- 20. When was your first menstrual period? \_\_\_\_\_
- When was your last menstrual period? \_\_\_\_\_
- What was the longest time between periods last year? \_\_\_\_\_

**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.

\*Explain all "YES" answers from medical history below:

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**I hereby state that, to the best of my knowledge, the answers to my medical history are correct.**

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Sports Pre-Participation Medical Evaluation**  
 (This is not a substitute for regular visits to your personal physician)

Name \_\_\_\_\_ Age \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_

**Visual Acuity**

\_\_\_\_\_ with correction \_\_\_\_\_ w/o correction  
 Left: 20/\_\_\_\_ Right: 20/\_\_\_\_  
 With contact lenses? \_\_\_\_\_yes \_\_\_\_\_no

**General Appearance**

Pupils: **L** \_\_\_\_\_ greater than \_\_\_\_\_ equal to \_\_\_\_\_ less than **R**  
 Eyes E.O.M: \_\_\_\_\_  
 Ear/Nose/Throat: \_\_\_\_\_  
 Lymph Nodes: \_\_\_\_\_  
 Cardiac: \_\_\_\_\_  
 Chest: \_\_\_\_\_  
 Abdomen: \_\_\_\_\_  
 Genitals: \_\_\_\_\_ not examined \_\_\_\_\_  
 Skin: \_\_\_\_\_  
 Maturity Assessment –Tanner Stage \_\_\_\_\_  
 Other/Remarks: \_\_\_\_\_

**Musculoskeletal Examination**  
 (Screening examination only)

General Posture/Gait \_\_\_\_\_  
 Neck & Spine \_\_\_\_\_  
 Shoulders \_\_\_\_\_  
 Elbow, Wrist, Hand \_\_\_\_\_  
 Hips \_\_\_\_\_  
 Knees \_\_\_\_\_  
 Ankles/Feet \_\_\_\_\_

**Key:** Normal \_\_\_\_\_  
 Abnormal \_\_\_\_\_ \*  
 Ligament Laxity (0,1,2,3)

If Abnormal, explain below:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DETAILED EXAMINATION FOR SELECTED AREAS**

Complete this section only if there is an abnormality on the musculoskeletal screening exam above, (e.g. if there is an abnormality on the screening exam of the knee only. You do not have to do all the parts of this exam section; you only have to do it when indicated. In this section, range of motion and strength should be evaluated.)

**Neck**

Flexion/Extension \_\_\_\_\_  
 Rotation Left/Right \_\_\_\_\_  
 Lateral Flexion Left/Right \_\_\_\_\_  
 Axial Compression \_\_\_\_\_

**Shoulder**

	Right	Left
Flexion/Extension	_____	_____
Abduction/Adduction	_____	_____
Internal/External Rotation	_____	_____
Impingement Signs	_____	_____
Instability Testing	_____	_____

**Lower Extremity**

	Right	Left
Flexibility/Biomechanics	_____	_____
Groin/Hip Flexors	_____	_____
Hamstring	_____	_____
Quadriceps	_____	_____
Calf/Heel Cords	_____	_____
Leg Lengths	_____	_____
Q Angle	_____	_____

**Knee**

	Right	Left
Flexion/Extension	_____	_____
Quadriceps Tone/Symmetry	_____	_____
Patella		
Patella Tendon	_____	_____
Tracking/Subluxation	_____	_____
Tibial Tubercle	_____	_____
Medial Collateral Ligament	_____	_____
Lateral Collateral Ligament	_____	_____
Anterior Cruciate Ligament	_____	_____
Posterior Cruciate Ligament	_____	_____
Menisci	_____	_____

**Ankle**

	Right	Left
Plantar Flexion	_____	_____
Dorsiflexion	_____	_____
Inversion	_____	_____
Eversion	_____	_____
Ligaments Stress Tests		
Anterior Drawer	_____	_____
Inversion/Talar Tilt	_____	_____

**Foot**

	Right	Left
	_____	_____

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**Sports Certification Statement**

**I hereby state that I have reviewed this student’s medical history and I certify that on this date I examined this student and that on the basis of this examination and the student’s medical history as furnished to me, it is permissible for the student-athlete to participate as indicated below.**

\_\_\_\_\_ **Cleared** for all classifications

\_\_\_\_\_ **Cleared** after completing evaluation/rehabilitation for: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ **Not cleared for:**

\_\_\_\_\_ **Contact/Collision** (football, soccer, wrestling)

\_\_\_\_\_ **Limited Contact** (baseball/softball, basketball, cheerleading, diving, high jump, pole vault, volleyball)

\_\_\_\_\_ **Non Contact**

\_\_\_\_\_ **Strenuous** (drill team, discus, javelin, shot put, running, swimming, tennis, weight lifting)

\_\_\_\_\_ **Non-Strenuous** (golf)

\_\_\_\_\_  
**Licensed Health Care Provider Signature**

\_\_\_\_\_  
**Date of Examination**

\_\_\_\_\_  
**Printed Name**

Circle Degree: MD DO PAC CNP DC

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Phone**

Reference material from the “American Academy of Pediatrics Committee on Sports Medicine”. Pediatrics Vol. 81, p 738, copyright 1988. For a copy of suggested guidelines of participation with injured or missing organs contact the Albuquerque Public Schools Athletic Office.

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