Albuquerque Public Schools Athletic Participation Requirements

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

PLEASE READ THE FOLLOWING STATEMENTS CONCERNING PARTICIPATION IN AN ALBUQUERQUE PUBLIC SCHOOLS (APS) 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 APS 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. APS 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 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.

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 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 (6.12) for all athletic, cheer, and dance/drift 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.
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. 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 and will not assume the financial responsibility for health care services.**

<table>
<thead>
<tr>
<th>APS Health/Accident Insurance carrier:</th>
<th>School</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Health/Accident Insurance Carrier</td>
<td>(Name of Carrier)</td>
<td></td>
</tr>
</tbody>
</table>

EMERGENCY CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Student-Athlete Name</th>
<th>Date of Birth</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/ Legal Guardian Name</td>
<td>Home Phone</td>
<td>Work Phone</td>
</tr>
<tr>
<td>Parent/Legal Guardian Name</td>
<td>Home Phone</td>
<td>Work Phone</td>
</tr>
</tbody>
</table>

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

(Complete prior to physical exam)

Student Athlete: _____________________ Age: _____ Grade ______

(Please Print)

DOB ___________________

Last Name: ___________ First Name: ___________ MI: ___________ Place of Birth: ___________________________

Month/Day/Year: ___________________

City: ___________ State: ___________ Last School Attended: ___________________________

Mailing Address: ___________________________ Street: ___________ City: ___________ St. ___________ Zip Code: ___________

Name of Parent/Legal Guardian: ___________________________

Home Ph. ___________________________

Contact Number: ___________________________

Explain "Yes" answers at the end of section

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?

   Hypophic 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.

   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.

   Have you had any broken or fractured bones or dislocated joints? If yes, Circle below.

   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?
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) 

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:**

________________________________________                                   ________________
Student-Athlete Signature                                                                                                                            Date

_________________________________________                                   ______________
Parent/ Legal Guardian Signature                                                                                                               Date

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS VALID AND CORRECT**
ATHLETIC PRE-PARTICIPATION PHYSICAL EXAM FORM

Student-Athlete Name ______________________________ Gender _______ DOB _______

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

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

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Findings/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>(any physical finding of Marfan’s syndrome)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/Ears/Nose/Throat (if indicated)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing (if indicated)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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/STRENUEOUS
  - Baseball, Basketball, Cheerleading, Track/Field (High Jump, Pole Vault) Softball, Volleyball.
- LIMITED CONTACT NON-CONTACT/NON-STRENUEOUS
  - 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 ___________________________