



# 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 your school's athletic department.

## Medical History – Parent/Guardian please fill out prior to examination.

Student Athlete Name (Last, First, M.I.):

Home Address:

Street City State Zip

Grade:

DOB:

AGE:

Name of Parent/Guardian

Home Address:

Street City State Zip

Phone:

Work:

Cell:

Emergency Contact

Name Relationship

Phone:

Work:

Cell:

Address:

Street City State Zip

## 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

\_\_\_\_\_  
Present or Court Appointed Legal Guardian Signature

\_\_\_\_\_  
Date

# ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

## Part A: Health History Form

Student Athlete Name \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_

1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>		<input type="checkbox"/>	No
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	25. Is there anyone in your family with asthma?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
5. Have you ever become dizzy or passed out DURING or AFTER exercise?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
6. Have you ever had discomfort, pain, or pressure in your chest during or after exercise?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
7. Do you get more tired than your friends do during exercise?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	29. Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
9. Has a doctor ever told you that you have: <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Infection <input type="checkbox"/> High Cholesterol (Check all that apply)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	30. Have you had a herpes infection?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
					31. Have you had a head injury or concussion?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
					32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
10. Has a doctor ever ordered a test for your heart?(for example ECG, echocardiogram)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	33. Have you ever had a seizure?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
11. Has anyone in your family ever died for no apparent reason?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	34. Do you have headaches with exercise?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
12. Does any one in your family have a heart problem?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	35. Have you ever had numbness or tingling or weakness in your arms, or legs?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
13. Has a family member or relative died of heart problems or sudden death before the age of 50?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	36. Have you ever been unable to move your arms or legs after being hit or fallen?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
14. Have any of your relatives ever had any one of the following conditions? Hypertrophic cardiomyopathy, dilated cardiomyopathy, Marfan's syndrome or Long QT Syndrome or a significant heart arrhythmia?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
					38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
15. Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
					40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
16. Have you ever spent the night in a hospital?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	41. Do you wear protective eyewear such as goggles or a face shield?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
17. Have you ever had surgery?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	42. Are you unhappy with your weight?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes circle affected area below:					43. Are you trying to gain or lose weight?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
					44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
					45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
					46. Do you have concerns that you would like to discuss with the doctor/health care provider?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
19. Have you had any broken or fractured bones or dislocated joints? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes circle affected area below:					FEMALES ONLY: 47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No				
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes circle affected are below:					48. How old were you when you had your first menstrual period? _____ 49. How many periods have you had in the last 12 months? _____				
Head	Neck	Shoulder	Upper arm	Elbow	Calf or shin	Hand	Chest		
Upper back	Lower Back	Forearm	Thigh	Knee	Hip	Ankle	Foot Toes		
21. Have you ever had a stress fracture?					<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
22. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?					<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
23. Do you regularly use a brace or assistive device?					<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	

**Explain "Yes" answers here (use the back of the form if necessary):**

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**ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM**

Part B: Physical Examination

Athlete Name \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_

TO BE COMPLETED BY THE EXAMINING PHYSICIAN OR PROVIDER -PLEASE COMPLETE BOTH PAGES

Student Athlete Name (Last, First, M.I.): \_\_\_\_\_ DOB: \_\_\_\_\_  
 Height \_\_\_\_\_ Weight: \_\_\_\_\_

BMI %ile \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_  
(Per CDC %ile charts) (Recheck if elevated) \_\_\_\_\_ / \_\_\_\_\_  
 Blood Pressure %ile \_\_\_\_\_  
(per NIH guidelines)

Vision: R20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Corrected: Y / N Pupils : Equal \_\_\_\_\_ Unequal \_\_\_\_\_

MEDICAL	Normal (circle one)		Abnormal Findings/Comments
	YES	NO	
Appearance	YES	NO	
Eyes/Ears/Nose/Throat	YES	NO	
Hearing	YES	NO	
Lymph nodes	YES	NO	
Heart (auscultation should be done supine and standing- abnormal findings require referral for further evaluation)	YES	NO	
Murmurs	YES	NO	
Pulses	YES	NO	
Lungs: Auscultation	YES	NO	
Abdomen: Assessment (incl. liver, spleen)	YES	NO	
Genitourinary (males only)	YES	NO	
Skin	YES	NO	
<b>MUSCULOSKELETAL</b>			
Neck	YES	NO	
Back	YES	NO	
Shoulder/Arm	YES	NO	
Elbow/Forearm	YES	NO	
Wrist/Hand/Fingers	YES	NO	
Hip/Thigh	YES	NO	
Knee	YES	NO	
Leg/Ankle	YES	NO	
Foot/Toes	YES	NO	

NOTES: \_\_\_\_\_

Does Athlete wear contacts?  Yes  No  
 Does Athlete require eye protection while playing?  Yes  No

Student MAY participate in the following types of sports (CHECK ALL THAT APPLY):  
 ALL FORMS OF SPORTS  CONTACT/COLLISION  NON-CONTACT/STRENUOUS  
 LIMITED CONTACT  NON-CONTACT/NON-STRENUOUS  
 STUDENT CLEARED FOR PARTICIPATION  
 STUDENT CLEARED FOR PARTICIPATION PENDING \_\_\_\_\_  
 STUDENT NOT CLEARED FOR PARTICIPATION

Name of Physician/Provider (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Physician /Provider \_\_\_\_\_

Student's Primary Physician/Provider (for follow up, if necessary): \_\_\_\_\_



## CLEARANCE FORM

Athlete Name: \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Field Hockey	Baseball	Discus	Bowling
Football	Basketball	Javelin	Golf
Ice Hockey	Cheerleading	Shot put	
Lacrosse	Diving	Rowing	
Soccer	Fencing	Running/Cross Country	
Wrestling	Field	Strength Training	
	High Jump	Swimming	
	Pole vault	Tennis	
	Gymnastics	Track	
	Skiing		
	Softball		
	Volleyball		

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

STUDENT CLEARED FOR ALL FORMS OF SPORTS

CONTACT/COLLISION    NON-CONTACT/STRENUOUS    LIMITED CONTACT    NON-CONTACT/NON-STRENUOUS

STUDENT CLEARED FOR PARTICIPATION

STUDENT CLEARED FOR PARTICIPATION PENDING: \_\_\_\_\_

STUDENT NOT CLEARED FOR PARTICIPATION

### STUDENT ATHLETE EMERGENCY INFORMATION

ALLERGIES \_\_\_\_\_ HISTORY OF ANAPHYLAXIS?    Yes    No

IMMUNIZATIONS    Up to date   Last Tetanus Immunization \_\_\_\_\_

**Significant Medical History Information** *(Please Include any history of asthma, hypertension, previous head injury, unequal pupil size etc.)*

**Student's Primary Physician/Provider** *(For follow up, if necessary):* \_\_\_\_\_

**Current Medical Conditions:**

**Current Medications** *(if on asthma medication please indicate if needed prior to sports):*

Does Athlete wear contacts?    Yes    No   Does Athlete require eye protection while playing?    Yes    No

Providers Name \_\_\_\_\_ MD \_\_\_ DO \_\_\_ NP \_\_\_ PA \_\_\_ DC   Phone: \_\_\_\_\_

**Address:**

Street                                  City                                  State                                  Zip

Signature of Provider \_\_\_\_\_ Date: \_\_\_\_\_