

The New Mexico Activities Association physical form provides schools, parents and providers with a recommended form.

If the NMAA recommended Physical Form is to be used, please ensure that your child's school grants permission to use this form and that no additional documentation is needed to gain athletic participation eligibility (i.e. parental permission form).



MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

(Cover sheet)

New Mexico Activities Association
6600 Palomas NE
Albuquerque, NM 87109
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.

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

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
16. Have you ever spent the night in a hospital?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	40. Do you wear glasses or contact lenses?	<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:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	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
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:	<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
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 area below:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	FEMALES ONLY:				
					47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No				
					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):

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: _____ / _____ Blood Pressure %ile _____
 (Per CDC %ile charts) (Recheck if elevated) _____ / _____ (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	

MUSCULOSKELETAL			
	YES	NO	
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: