



# 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.

<b>Student Athlete Name</b> ( <i>Last, First, M.I.</i> ):					
Home Address:				Grade:	
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>		
DOB:				AGE:	
<b>Name of Parent/Guardian</b>					
Home Address:				Phone:	Work:
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>	Cell:	
<b>Emergency Contact</b>				Phone:	Work:
<i>Name</i>		<i>Relationship</i>		Cell:	
Address:					
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>		
<b>SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN (CHECK ALL THAT APPLY)</b>					
<b>Sports/Activities</b>					
<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		
<p>Please answer all health history questions on the following page <b>PRIOR</b> 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.</p>					

# ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

**HISTORY**

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

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Please Print) Last First MI

Place of Birth: \_\_\_\_\_ Last School Attended: \_\_\_\_\_  
City State School City State

Mailing Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Street City State Zip

Name of Parent/Guardian: \_\_\_\_\_ Work / Cell Phone: \_\_\_\_\_

**Explain "Yes" answers below**

- |  | Yes | No |   | Yes | No |
|--|-----|----|---|-----|----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?   | ✓   | ✓  | 21. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?                 | ✓   | ✓  |
| 2. Do you have an ongoing medical condition (like asthma or diabetes)?   | ✓   | ✓  | 22. Do you regularly use a brace or assistive device?   | ✓   | ✓  |
| 3. Are you currently taking any prescription or nonprescription medications or pills?  | ✓   | ✓  | 23. Has a doctor ever told you that you have asthma or allergies?   | ✓   | ✓  |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?  | ✓   | ✓  | 24. Do you cough, wheeze, or have difficulty breathing during or after exercise?                                    | ✓   | ✓  |
| 5. Have you ever become dizzy or passed out <b>During or After</b> exercise?   | ✓   | ✓  | 25. Is there anyone in your family with asthma?   | ✓   | ✓  |
| 6. Have you ever had chest discomfort, pain or pressure during or after exercise?  | ✓   | ✓  | 26. Have you ever used an inhaler or taken asthma medicine?   | ✓   | ✓  |
| 7. Do you get more tired than your friends during exercise?  | ✓   | ✓  | 27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ?                      | ✓   | ✓  |
| 8. Has a doctor ever told you that you have: (check all that apply)  | ✓   | ✓  | 28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month? | ✓   | ✓  |
| <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur   |     |    | 29. Do you have any rashes, pressure sores or other skin problems?  | ✓   | ✓  |
| <input type="checkbox"/> Heart infection <input type="checkbox"/> High cholesterol   |     |    | 30. Have you had a herpes infection?  | ✓   | ✓  |
| 9. Has a doctor ever ordered a test for your heart? (ECG, echocardiogram)  | ✓   | ✓  | 31. Have you had a head injury or concussion?   | ✓   | ✓  |
| 10. Has anyone in your family ever died for no apparent reason?  | ✓   | ✓  | 32. Have you been hit in the head and been confused or lost your memory?  | ✓   | ✓  |
| 11. Does anyone in your family have a heart condition starting under the age of 50?  | ✓   | ✓  | 33. Have you ever had seizure?  | ✓   | ✓  |
| 12. Has a family member or relative died of heart problems or sudden death before the age of 50?   | ✓   | ✓  | 34. Do you have headaches with exercise?  | ✓   | ✓  |
| 13. Have any of relatives ever had one of the following conditions? Hypertrophic cardiomyopathy, Marfan's syndrome, Long QT syndrome or a significant heart arrhythmia | ✓   | ✓  | 35. Have you ever had numbness or tingling or weakness in your arms or legs?  | ✓   | ✓  |
| 14. Have you ever had racing of your heart or skipped heart beats?   | ✓   | ✓  | 36. Have you ever been unable to move your arms or legs after being hit or fallen?                                  | ✓   | ✓  |
| 15. Have you ever spent the night in a hospital?   | ✓   | ✓  | 37. When exercising in the heat, do you have severe muscle cramps or become ill?                                    | ✓   | ✓  |
| 16. Have you ever had surgery?   | ✓   | ✓  | 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?          | ✓   | ✓  |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? (if Yes, circle below)               | ✓   | ✓  | 39. Have you had any problems with your eyes or vision?   | ✓   | ✓  |
| 18. Have you had any broken or fractured bones or dislocated joints? (if yes, circle below)  | ✓   | ✓  | 40. Do you wear glasses or contacts?  | ✓   | ✓  |
| 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?         | ✓   | ✓  | 41. Do you wear protective eyewear such as goggles or a face shield?  | ✓   | ✓  |
| Head   Neck   Shoulder   Upper arm   Elbow   |     |    | 42. Are you unhappy with your weight?   | ✓   | ✓  |
| Calf   Hand   Chest   Upper back   Lower back  |     |    | 43. Are you trying to gain or lose weight?  | ✓   | ✓  |
| Forearm   Thigh   Knee   Ankle   Foot   Toes   |     |    | 44. Has anyone recommended you change your weight or eating habits?   | ✓   | ✓  |
| 20. Have you ever had a stress fracture?   | ✓   | ✓  | 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?                     | ✓   | ✓  |
|  |     |    | <b>FEMALES ONLY:</b>  |     |    |
|  |     |    | 47. Have you ever had a menstrual period?   | ✓   | ✓  |
|  |     |    | 48. How old were you when you had your first menstrual period? _____  |     |    |
|  |     |    | 49. How many periods have you had in the last 12 months? _____  |     |    |

**Explain "Yes" answers here:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS VALID AND CORRECT:**

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

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

Date \_\_\_\_\_

**I VERIFY THAT I HAVE REVIEWED THE ABOVE INFORMATION**

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

**ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM** **PHYSICAL EXAMINATION**

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

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_, (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_)

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

<b>MEDICAL</b>	<b>Normal</b>	<b>Abnormal</b>	<b>Findings/Comments</b>
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Appearance			
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(any physical finding of Marfan's syndrome)			
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Eyes/Ears/Nose/Throat ( <i>if indicated</i> )			
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Hearing ( <i>if indicated</i> )			
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**Heart** (*auscultation should be done supine and standing- abnormal findings require referral for further evaluation*)

Murmurs			
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Pulses			
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Lungs: Auscultation			
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Abdomen:			
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Genitourinary ( <i>only if indicated</i> )			
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Skin			
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**MUSCULOSKELETAL**

Neck			
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Back			
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Shoulder/Arm			
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Elbow/Forearm			
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Wrist/Hand/Fingers			
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Hip/Thigh			
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Knee			
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Leg/Ankle			
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Foot/Toes			
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NOTES: \_\_\_\_\_

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 PENDING (explanation)

STUDENT NOT CLEARED FOR PARTICIPATION (explanation)

Name of Physician/Provider (print/type) _____	Date _____
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Signature of Physician /Provider _____	
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Student's Primary Physician/Provider (for follow up, if necessary): _____
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