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

<table>
<thead>
<tr>
<th>Student Athlete Name <em>(Last, First, M.I.)</em>:</th>
<th>Grade:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address:</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
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<tr>
<td>DOB:</td>
<td>AGE:</td>
</tr>
<tr>
<td>Name of Parent/Guardian</td>
<td></td>
</tr>
<tr>
<td>Home Address:</td>
<td></td>
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<td>Street</td>
<td>City</td>
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<td>Phone:</td>
<td>Work:</td>
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<td>Work:</td>
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<td>Cell:</td>
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<tr>
<td>Emergency Contact</td>
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<tr>
<td>Phone:</td>
<td>Work:</td>
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<tr>
<td>Work:</td>
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<td>Cell:</td>
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<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
</tr>
</tbody>
</table>

## SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN *(CHECK ALL THAT APPLY)*

- **Baseball**
- **Football**
- **Cheer/Drill**
- **Wrestling**
- **Bowling**
- **Track/Field**
- **Tennis**
- **Volleyball**
- **Golf**
- **Other**
- **Cross country**
- **Soccer**
- **Softball**
- **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
Preparticipation Physical Evaluation

NAME: ___________________________ DATE OF EXAM: ________________

SEX: ___________________ AGE: _______ GRADE: _______ SCHOOL: ____________ SPORT(S) _______

Date of birth ________________________

**Medications and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

__________________________________________________________________________________

Do you have any allergies? □ Yes □ No If yes, please identify specific allergy below.
□ Medicines □ Pollens □ Food □ Stinging Insects

**General Questions**

1. Has a doctor ever denied or restricted your participation in sports for any reason? __________

2. Do you have any ongoing medical conditions? If so, please identify below: □ Asthma □ Anemia □ Diabetes □ Infections □ Other: __________________________

3. Have you ever spent the night in the hospital? __________

4. Have you ever had surgery? __________

5. Have you ever passed out or nearly passed out DURING or AFTER exercise? __________

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? __________

7. Does your heart ever race or skip beats (irregular beats) during exercise? __________

8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:
   - High blood pressure
   - High cholesterol
   - Kawasaki disease
   - Other: __________________________

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) __________

10. Do you get lightheaded or feel more short of breath than expected during exercise? __________

11. Have you ever had an unexplained seizure? __________

12. Do you get more tired or short of breath more quickly than your friends during exercise? __________

**Health Questions About You**

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? __________

14. Does anyone in your family have hypothyroidism or Marfan syndrome, hereditary heart rhythm disorders, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? __________

15. Has anyone in your family a heart problem, pacemaker, or implanted defibrillator? __________

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? __________

**Bone and Joint Questions**

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? __________

18. Have you ever had any broken or fractured bones or dislocated joints? __________

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? __________

20. Have you ever had a stress fracture? __________

21. Have you ever been told that you have or you have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) __________

22. Do you regularly use a brace, orthotics, or other assistive device? __________

23. Have you or someone in your family had an injury to a bone, muscle, or joint injury that bothered you? __________

24. Do any of your joints become painful, swollen, feel warm, or look red? __________

25. Have you ever had an injury to a bone, muscle, or joint injury that bothered you? __________

**Medical Questions**

26. Have you had any history of juvenile arthritis or connective tissue disease? __________

27. Do you have any history of seizure disorder? __________

28. Do you have a bone, muscle, or joint injury that bothers you? __________

29. Have you ever had any broken or fractured bones or dislocated joints? __________

30. Do you have iron deficiency anemia? __________

31. Do you or someone in your family have sickle cell trait or disease? __________

32. Do you have a history of seizures? __________

33. Have you ever had a heart infection? (For example, Kawasaki disease) __________

34. Have you ever had any history of allergies? (For example, eczema, asthma, hives) __________

35. Have you ever had any history of hyperthyroidism or hypothyroidism? __________

36. Have you ever had any heart block? __________

37. Have you ever had a head injury or concussion? __________

38. Have you ever had any nausea, vomiting, or diarrhea that caused you to miss a practice or a game? __________

39. Have you ever had any problems with your eyes or vision? (For example, visual acuity, visual field) __________

40. Have you ever had any history of glaucoma? __________

41. Have you or someone in your family have a history of heart problems? __________

42. Do you or someone in your family have a heart problem? __________

43. Have you ever had any history of asthma? __________

44. Have you ever had any history of diabetes? __________

45. Have you ever had any history of a blood disorder? __________

46. Have you ever had any history of anemia? __________

47. Have you ever had any history of a kidney problem? __________

48. Have you ever had any history of a blood disorder? __________

49. Have you ever had any history of a kidney problem? __________

50. Have you ever had any history of a skin disorder? __________

51. Have you or someone in your family have a history of skin problems? __________

52. Have you ever had any history of a skin disorder? __________

53. Have you ever had any history of a skin disorder? __________

54. Have you ever had any history of a skin disorder? __________

55. Have you ever had any history of a skin disorder? __________

56. Have you ever had any history of a skin disorder? __________

57. Have you ever had any history of a skin disorder? __________

58. Have you ever had any history of a skin disorder? __________

59. Have you ever had any history of a skin disorder? __________

**Females Only**

52. Have you ever had an menstrual period? __________

53. How old were you when you had your first menstrual period? __________

54. How many periods have you had in the last 12 months? __________

Explain “yes” answers here

__________________________________________________________________________

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ___________________________ Date __________________

Signature of parent/guardian ___________________________ Date __________________
## PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

### EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>BP</th>
<th>Pulse</th>
<th>Vision R 20/</th>
<th>L 20/</th>
<th>Corrected</th>
<th>Y</th>
<th>N</th>
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<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/ears/nose/throat</td>
<td></td>
<td></td>
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<tr>
<td>• Pupils equal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Murmurs (auscultation standing, supine, +/- Valsalva)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Location of point of maximal impulse (PMI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Simultaneous femoral and radial pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary (males only)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• HSV, lesions suggestive of MRSA, linea corporis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic*</td>
<td></td>
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</tr>
</tbody>
</table>

| MUSCULOSKELETAL |        |                    |
| Neck |
| Back |
| Shoulder/arm |
| Elbow/forearm |
| Wrist/hand/fingers |
| Hip/thigh |
| Knee |
| Leg/ankle |
| Foot/toes |
| Functional |
| • Duck-walk, single leg hop |

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
*Consider (D) exam if in private setting. Having third party present is recommended.
*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

☐ Not cleared
  ☐ Pending further evaluation
  ☐ For any sports
  ☐ For certain sports

Reason

Recommendations

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) __________________________ Date __________________
Address __________________________ Phone __________________________
Signature of physician __________________________, MD or DO

WHAT IS A CONCUSSION?
A concussion is an injury that changes how the cells in the brain normally work. A concussion is caused by a blow to the head or body that causes the brain to move rapidly inside the skull. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious. Concussions can also result from a fall or from players colliding with each other or with obstacles, such as a goalpost.

WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

**Observed by the Athlete**
- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion
- Does not “feel right”

**Observed by the Parent / Guardian**
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Can’t recall events after hit or fall
- Appears dazed or stunned

WHAT TO DO IF SIGNS/SYMPTOMS OF A CONCUSSION ARE

**Athlete**
- TELL YOUR COACH IMMEDIATELY!
- Inform Parents
- Seek Medical Attention
- Give Yourself Time to Recover

**Parent / Guardian**
- Seek Medical Attention
- Keep Your Child Out of Play
- Discuss Plan to Return with the Coach

It’s better to miss one game than the whole season.

Give yourself time to get better. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Second or later concussions can cause damage to your brain. It is important to rest until you get approval from a doctor or health care professional to return to play.
RETURN TO PLAY GUIDELINES UNDER SB38

1. Remove immediately from activity when signs/symptoms are present.
2. Must not return to full activity prior to a minimum of 240 hours (10 days).
3. Release from medical professional required for return.
4. Follow school district’s return to play guidelines.
5. Coaches continue to monitor for signs/symptoms once athletes return to activity.

Students need cognitive rest from the classroom, texting, cell phones, etc.

REFERENCES ON SENATE BILL 38 AND BRAIN INJURIES

Senate Bill 38:

For more information on brain injuries check the following websites:
https://nfhslearn.com/courses/61059/concussion-for-students
http://www.nfhs.org/resources/sports-medicine
http://www.cdc.gov/concussion/HeadsUp/youth.html
http://www.stopsportsinjuries.org/concussion.aspx
http://www.ncaa.org/health-and-safety/medical-conditions/concussions

SIGNATURES

By signing below, parent/guardian and athlete acknowledge the following:

- Both have received and reviewed the attached NMAA’s Concussion in Sports Fact Sheet for Athletes and Parents.
- Both understand the risks of brain injuries associated with participation in school athletic activity, and are aware of the State of the New Mexico’s Senate Bill 38; Concussion Law.
- Athlete has received brain injury training pursuant to Senate Bill 38.

_______________________________   _______________________________   ____________________________  
Athlete’s Signature                  Print Name                        Date

_______________________________   _______________________________   ____________________________  
Parent/Guardian’s Signature          Print Name                        Date
We have three Urgent Care Clinics in Albuquerque, NM and Los Lunas, NM. We are located at:

Urgent Care in Albuquerque, NM (Juan Tabo)
Duke City Urgent Care Clinics
Call (505) 207-3421
Visit 11601 Montgomery Blvd. NE, Albuquerque, NM 87111
Open Mon – Fri: 9am – 7pm, Sat – Sun: 10am – 6pm

Urgent Care in Albuquerque, NM (Louisiana Plaza)
Duke City Urgent Care Clinics
Call (505) 715-6812
Visit 7200 Montgomery Blvd Suite 7121, Albuquerque, NM 87109
Open Mon – Fri: 9am – 7pm, Sat – Sun: 10am – 6pm

Urgent Care in Los Lunas, NM (Valencia)
Duke City Urgent Care Clinics
Call (505) 539-1172
Visit 311 Los Lentes Rd SE, Los Lunas, NM 87031
Open Mon – Fri: 8am – 6pm, Sat – Sun: 10am – 6pm