



VOLUNTARY ACTIVITIES PARTICIPATION FORM ACKNOWLEDGEMENT AND ASSUMPTION OF POTENTIAL RISK

We the parent(s)/guardian(s) and student athlete are aware that preparation for participation in interscholastic athletics and intramurals involves many risks of serious and permanent injury to the student athlete. We understand and acknowledge that by their very nature, these activities pose potential dangers to individuals who participate in such programs.

I understand and acknowledge that participation in these activities is completely voluntary and as such is not required by the District. I understand and acknowledge that in order to participate in these activities. I agree to assume liability and responsibility for any and all potential risks which may be associated with participation in such activities. I understand, acknowledge and agree that the District, its employees, officers, agents or volunteers shall not be liable for any injury/illness suffered by me which is incident to and/or associated in preparing for and/or participating in this activity.

MATURITY STATEMENT:

Statistics indicate that there is an increase in the number of sport injuries with students who are not of a comparable maturity level as other participants. If you feel that your student might be subject to potential injury because of his/her state of development, please discuss this with them.

OFF-CAMPUS:

| | | |
|---------------------|--------------------|-----------------------------|
| _____ | _____ | _____ |
| Home Telephone | Business Telephone | Parent/Guardian's Signature |
| _____ | _____ | _____ |
| Emergency Telephone | Business Telephone | Parent/Guardian's Signature |
| _____ | | _____ |
| Date | | Student Athlete's Signature |

In addition to extracurricular competition, there are occasions where practice sessions for various programs are conducted off campus. This may consist of conditioning drills conducted off campus or involve students transporting themselves to nearby facilities.

We parent(s)/guardian(s) and student athlete have completely read, fully understand and voluntarily accept and agree to all of the above terms and conditions.

A signed voluntary activities participation form must be on file with the District before a student will be allowed to participate in the above extracurricular/curricular activities. THIS FORM MUST BE IN THE POSSESSION OF THE COACH ON ALL OUT OF TOWN TRIPS, AND KEPT ON FILE.

**CONTRACT HEALTH SERVICE INFORMATION
FOR NATIVE AMERICAN STUDENTS**

The Contract Health Service eligibility factors are set forth in Federal Regulations 42 C.F.R. 36, the Indian Health Manual, Part 2 Chapter 3 and the Navajo Area C.H.S. Medical Priority Policy. Copies are available from the Contract Health Service Specialist at any Indian Health Service Unit Hospital or Clinic.

The following information must be as complete as possible:

PLEASE PRINT OR TYPE ONLY!

Athlete: _____ Date of Birth: _____ IHS# _____

SS# _____ Sex: _____ Tribe: _____ Census# _____

Mailing Address: _____

Location of Home: _____

Name & Address of Parents' Employer or Income Source: _____

REMEMBER: Permission must be granted from the local Indian Health Service Director on duty within 72 hours, other wise, payment for services rendered becomes the responsibility of the athlete and/or parents.



NMAA PRE-PARTICIPATION EVALUATION (PPE) PACKET

In accordance with New Mexico Activities Association Bylaw 6.15, the following sports physical packet must be used for all pre-participation examinations.

PURPOSE

The PPE is designed to **screen for injuries, illnesses, or other factors that increase an athlete's risk for injury or illness.** Experts in the field of athletic training, sports medicine, orthopaedics, family medicine, pediatrics, and osteopathics agree that the identification of predisposing factors that threaten one's safety are vital to participation in sport and will serve to improve the health and safety of athletes and active individuals.

The NMAA employs the use of the Preparticipation Physical Evaluation (PPE) Monograph, 5th Edition. The PPE Monograph was developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine. It is also endorsed by the National Athletic Trainers' Association and the National Federation of State High School Associations. The NMAA Sports Medicine Advisory Committee also endorses the use of the 5th PPE Monograph.

NMAA PPE REQUIRED FORMS

| | Completed |
|--|--------------------------|
| ✓ Emergency Information (parent/guardian) | <input type="checkbox"/> |
| ✓ *Medical History (parent/guardian) | <input type="checkbox"/> |
| ✓ *Physical Examination (HCP) | <input type="checkbox"/> |
| ✓ Medical Eligibility (HCP) | <input type="checkbox"/> |
| ✓ Consent to Treat (parent/guardian) | <input type="checkbox"/> |
| ✓ Concussion Awareness (parent/guardian/student) | <input type="checkbox"/> |

****Medical History and Physical Examination forms should remain with the parent/guardian and/or health care provider, unless parent/guardian provides written authorization to release the forms to the school.***

FOR PARENTS

- ✓ The **Medical History** form should be filled out jointly with your son or daughter prior to the appointment.
- ✓ Please pay special attention to the "**Heart Health Questions**" listed on the **Medical History** form.
- ✓ The **Medical History** and **Physical Examination** forms should remain with you and/or your health care provider unless written authorization is provided to release this information to the school.
- ✓ Return all other forms to the school. No forms need to be returned to the New Mexico Activities Association.

FOR SCHOOLS

- ✓ Schools should collect **Emergency Information, Medical Eligibility, Consent to Treat, and Concussion Awareness** forms.
- ✓ The **Medical History** and **Physical Examination** forms should NOT be collected unless written authorization is received from the parent/guardian.

NOTES FOR APPROVED HCP

- ✓ Healthcare providers should review **Medical History** prior to evaluation and **retain a copy in the medical file.**
- ✓ Healthcare providers should complete and sign the **Physical Examination** and **Medical Eligibility** forms.
- ✓ **Medical Eligibility** form should be returned to the parent/guardian to submit to the school.
- ✓ **Medical History** and **Physical Examination** forms should be returned to the parent/guardian to secure.
- ✓ **American Academy of Pediatrics Cardiac Screening Guidance:**
 - Primary care providers should be aware of features of the clinical history, family history and physical examination suggestive of a risk for SCA/SCD.
 - A thorough history, family history and physical examination are necessary to begin assessing for SCA/SCD risk.
 - The ECG should be the first test ordered when there is concern for SCA risk. It should be interpreted by a medical provider trained in recognizing electrical heart disease.
 - Survivors of SCA and family members of those with SCA or SCD should have a thorough evaluation to assess for a potential genetic etiology.



EMERGENCY INFORMATION

(Parent/Guardian, please fill out prior to examination)

STUDENT INFORMATION

NAME (Last, First, MI): _____ AGE: ____ GRADE: ____ DATE OF BIRTH: __/__/__

EMAIL ADDRESS: _____ CELL PHONE: _____

HOME ADDRESS: _____
Street City State Zip

PARENT/GUARDIAN INFORMATION #1

NAME (Last, First): _____

PRIMARY PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

HOME ADDRESS: _____
Street City State Zip

PARENT/GUARDIAN INFORMATION #2 (if applicable)

NAME (Last, First): _____

PRIMARY PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

HOME ADDRESS: _____
Street City State Zip

EMERGENCY CONTACT

NAME (Last, First): _____

PRIMARY PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

HOME ADDRESS: _____
Street City State Zip

PARTICIPANT INSURANCE (Participants must be covered by accident/injury insurance prior to participation)

| | | |
|-------------------|---------------|----------|
| | | |
| Insurance Carrier | Policy Number | Group ID |

SPORTS PARTICIPATING (Check all that apply)

| Fall | Winter | Spring | Other |
|--|--|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Cross Country | <input type="checkbox"/> Basketball | <input type="checkbox"/> Baseball | <input type="checkbox"/> Bowling |
| <input type="checkbox"/> Football | <input type="checkbox"/> Cheer | <input type="checkbox"/> Golf | <input type="checkbox"/> |
| <input type="checkbox"/> Soccer | <input type="checkbox"/> Dance | <input type="checkbox"/> Softball | <input type="checkbox"/> |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Powerlifting | <input type="checkbox"/> Tennis | <input type="checkbox"/> |
| | <input type="checkbox"/> Swimming/Diving | <input type="checkbox"/> Track/Field | |
| | <input type="checkbox"/> Wrestling | | |

PARENT/GUARDIAN VERIFICATION (Print, Sign & Date)

Print Name _____ Sign Name _____

Date _____

A copy of this form should be placed into the athlete's medical file and should not be shared with schools or sports organizations without written authorization from parent/guardian.

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____

Have you had COVID-19? (check one): Y N

Have you been immunized for COVID-19? (check one): Y N If yes, have you had: One shot Two shots
 Three shots Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

| | Not at all | Several days | Over half the days | Nearly every day |
|---|------------|--------------|--------------------|------------------|
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

| GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.) | Yes | No |
|--|-----|----|
| 1. Do you have any concerns that you would like to discuss with your provider? | | |
| 2. Has a provider ever denied or restricted your participation in sports for any reason? | | |
| 3. Do you have any ongoing medical issues or recent illness? | | |
| HEART HEALTH QUESTIONS ABOUT YOU | Yes | No |
| 4. Have you ever passed out or nearly passed out during or after exercise? | | |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | | |
| 7. Has a doctor ever told you that you have any heart problems? | | |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. | | |

| HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED) | Yes | No | |
|---|--------|-----|----|
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise? | | | |
| 10. Have you ever had a seizure? | | | |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY | Unsure | Yes | No |
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? | | | |
| 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? | | | |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | | | |

| BONE AND JOINT QUESTIONS | | Yes | No |
|---|--------|-----|----|
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | | | |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? | | | |
| MEDICAL QUESTIONS | | Yes | No |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | | |
| 17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ? | | | |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | | | |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)? | | | |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | | | |
| 21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? | | | |
| 22. Have you ever become ill while exercising in the heat? | | | |
| 23. Do you or does someone in your family have sickle cell trait or disease? | Unsure | | |
| 24. Have you ever had or do you have any problems with your eyes or vision? | | | |

| MEDICAL QUESTIONS (CONTINUED) | | Yes | No | |
|--|--|-----|-----|----|
| 25. Do you worry about your weight? | | | | |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? | | | | |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? | | | | |
| 28. Have you ever had an eating disorder? | | | | |
| MENSTRUAL QUESTIONS | | N/A | Yes | No |
| 29. Have you ever had a menstrual period? | | | | |
| 30. How old were you when you had your first menstrual period? | | | | |
| 31. When was your most recent menstrual period? | | | | |
| 32. How many periods have you had in the past 12 months? | | | | |

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

This form should be returned to the parent to secure and should not be shared with schools or sports organizations without written authorization from parent/guardian.

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- 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, e-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-enhancing 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

| EXAMINATION | | |
|---|---------|--|
| Height: | Weight: | |
| BP: / (/) | Pulse: | Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N |
| MEDICAL | NORMAL | ABNORMAL FINDINGS |
| Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | | |
| Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing | | |
| Lymph nodes | | |
| Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | | |
| Lungs | | |
| Abdomen | | |
| Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis | | |
| Neurological | | |
| MUSCULOSKELETAL | NORMAL | ABNORMAL FINDINGS |
| Neck | | |
| Back | | |
| Shoulder and arm | | |
| Elbow and forearm | | |
| Wrist, hand, and fingers | | |
| Hip and thigh | | |
| Knee | | |
| Leg and ankle | | |
| Foot and toes | | |
| Functional <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test | | |

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization. History and Physical Examination forms should not be shared with schools or sports organizations without written authorization from parent/guardian.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

- Medically eligible for certain sports

- Not medically eligible pending further evaluation
- Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____

NEW MEXICO ACTIVITIES ASSOCIATION

6600 PALOMAS AVE. NE
ALBUQUERQUE, NM 87109
PHONE: 505-923-3110
FAX: 505-923-3114



CONSENT TO TREAT FORM

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances, it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, as a member of the New Mexico Activities Association (NMAA), _____ (name of school or district) requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/NMAA, to the extent the QMP deems necessary to prevent harm to the student/athlete. It is understood that a QMP may be an athletic trainer, medical/osteopathic physician, physician assistant or nurse practitioner licensed by the state of New Mexico (or the state in which the student/athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by New Mexico law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designated by state regulation and standing protocols, and not for the purpose of making decisions about return to play.

PLEASE PRINT LEGIBLY OR TYPE

"I, _____ the undersigned, am the parent/legal guardian of, _____, a minor and student-athlete at _____ (name of school or district) who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/NMAA may employ or designate QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the designated state license, except as otherwise limited by New Mexico law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/NMAA."

Date: _____ **Signature:** _____



CONCUSSION IN SPORTS

A Fact Sheet for Athletes and Parents

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:

<https://www.nmlegis.gov/Sessions/17%20Regular/final/SB0038.pdf>

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