Mesilla Valley Christian Schools

MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

Note to Parents/Guardians: In order that the best plans may be made for your child, it is necessary that we have your cooperation in filling out this questionnaire accurately and the school must have this form on file before he/she can participate in the first practice session and in interscholastic competition sports (NMAA and SWCAA). Physicals are only good for the current school year.

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM
Part A: Health History Form
Student Athlete Name

Name of Student _____ Grade _____

Date of Birth_____ Gender _____ Age _____

Home Address _____

Name of Parent/Guardian _____

Home Address _____

Phone: Home _____ Cell _____ Office _____ Emergency _____

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes ☐ No ☐
2. Do you have an ongoing medical condition (like diabetes or asthma)? Yes ☐ No ☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Yes ☐ No ☐
4. Do you have allergies to medicines pollens, foods, or stinging insects? Yes ☐ No ☐
5. Have you ever become dizzy or passed out **DURING** or **AFTER** exercise? Yes ☐ No ☐
6. Have you ever had discomfort, pain, or pressure in your chest during or after exercise? Yes ☐ No ☐
7. Do you get more tired than your friends do during exercise? Yes ☐ No ☐
8. Has a doctor ever told you that you have:
   ☐ High Blood Pressure ☐ Heart Murmur
   ☐ Heart Infection ☐ High Cholesterol
   (Check all that apply)
9. Has anyone in your family ever died for no apparent reason? Yes ☐ No ☐
10. Does anyone in your family have a heart problem? Yes ☐ No ☐
11. Has a doctor ever ordered a test for your heart? (Example ECG, echocardiogram) Yes ☐ No ☐
12. Has a family member or relative died of heart problems or sudden death before the age of 50? Yes ☐ No ☐
13. 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? Yes ☐ No ☐
14. Have you ever had racing of your heart or skipped heartbeats? Yes ☐ No ☐
15. Have you ever spent the night in a hospital? Yes ☐ No ☐
16. Have you ever had surgery? Yes ☐ No ☐
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? Yes ☐ No ☐
18. 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? Yes ☐ No ☐
19. Have you had any broken or fractured bones or dislocated joints? Yes ☐ No ☐

(If yes for questions 17-19 please explain)

_____

_____

_____

_____

20. Have you ever had a stress fracture? Yes ☐ No ☐
21. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability? Yes ☐ No ☐
22. Do you regularly use a brace or assistive device? Yes ☐ No ☐
23. Has a doctor ever told you that you have asthma or allergies? Yes ☐ No ☐
24. Do you cough, wheeze or have difficulty breathing during or after exercise? Yes ☐ No ☐
25. Is there anyone in your family with asthma? Yes ☐ No ☐
26. Have you ever used an inhaler or taken asthma medicine? Yes ☐ No ☐
27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ? Yes ☐ No ☐
28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month? Yes ☐ No ☐
29. Do you have any rashes, pressure sores or other skin problems? Yes ☐ No ☐
30. Have you had a herpes infection? Yes ☐ No ☐
31. Have you had a head injury or concussion? Yes ☐ No ☐
32. Have you been hit in the head and been confused or lost your memory? Yes ☐ No ☐
33. Have you ever had a seizure? Yes ☐ No ☐
34. Do you have headaches with exercise? Yes ☐ No ☐
35. Have you ever had numbness or tingling or weakness in your arms or legs? Yes ☐ No ☐
36. Have you ever been unable to move your arms or legs after being hit or fallen? Yes ☐ No ☐
37. When exercising in the heat, do you have severe muscle cramps or become ill? Yes ☐ No ☐
38. Have you had any problems with your eyes or vision? Yes ☐ No ☐
39. Do you wear glasses or contact lenses? Yes ☐ No ☐
40. Do you wear protective eyewear such as goggles or a face shield? Yes ☐ No ☐
41. Are you unhappy with your weight? Yes ☐ No ☐
42. Are you trying to gain or lose weight? Yes ☐ No ☐
43. Has anyone recommended you change your weight or eating habits? Yes ☐ No ☐
44. Do you limit or carefully control what you eat? Yes ☐ No ☐
45. Do you have concerns that you would like to discuss with the doctor/health care provider? Yes ☐ No ☐

FEMALES ONLY:

46. Have you ever had a menstrual period? Yes ☐ No ☐
47. How old were you when you had your first menstrual period?_____
48. How many periods have you had in the last 12 months? _____

Explain "Yes" answers here:

_____

_____

_____

_____

_____

_____

_____

_____

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

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM
Part B: Physical Examination
Athlete Name _____ **Gender** _____ **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**
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			
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	

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_____

Contact/Collision	Limited Contact	Strenuous	Non-Strenuous
Football	Baseball	Running/Cross Country	Golf
	Basketball	Strength Training	
	Cheerleading	Swimming	
	Diving	Tennis	
	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:_____

Signature of Provider:_____ Date:_____

To Parent/Guardian and Student Athlete

Please read the following statements concerning the participation of your child/ward in interscholastic athletics. Respond below with your signature.

INSURANCE

Insurance Provider_____

Insurance Phone Number_____

Insurance Policy Number_____

PARENTAL CONSENT

I hereby give my consent for _____
to participate in interscholastic athletics at Mesilla Valley Christian Schools. The financial responsibility for securing care of athletic injuries is a matter between the parent/guardian and physician/doctor of osteopathy/physician's assistant or dentist of parent's/guardians selection. Mesilla Valley Christian Schools may not pay doctors, dentists or hospitals for any treatment of any child.

MEDICAL HISTORY

I hereby state that I have reviewed the medical history of my child and find the answers to the questions correct to the best of my knowledge.

AUTHORIZATION FOR MEDICAL SERVICES

The Parents/Guardians request that I/we be contacted within a reasonable time in the event of illness or injury requiring medical service. In the event I/we cannot be reached, the Parents/Guardians hereby designate the Athletic Director, Team Coach, Athletic Trainer or their designee to act in my/our behalf to authorize such hospitalization, medical attention and surgery as may be required in an emergency because of illness or injuries sustained by my/our child/ward while participating in school athletics. In the event I/we cannot be reached, and the situation calls for medical attention, I/we recognize and relinquish my/our responsibility to a practicing physician/doctor of osteopathy/physician's assistant and/or medical personnel acting in the best interest of my/our child/ward. I/We hereby assume financial responsibility for hospitalization, medical attention and surgery provided.

I/We the parents grant permission for medication administration and treatment for minor injuries sustained for my/our child/ward. Medications to be administered at time of need will be ibuprofen 400mg, Tylenol (Acetaminophen) 650mg, Benadryl 12.5mg. Doses may be changed to the above medications depending on childs weight, health status and injury. Betadine solution to clean wounds, triple antibiotic ointment for wounds, an antibiotic/pain relieving ointment such as Neosporin, Bacitracin for wounds If athlete faints the ammonia salt will be used to awake them. In the case of an injury to stabilize the injured area until medical attention arrives. Information for these uses can be granted if requested by parent. Upon signing this consent you authorize the Athletic Director, Team Coach and Athletic Trainer to carry out these measures. Any of the listed above who in good faith complies with this form, rules and regulations cannot be held liable for cost for treatment.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Phone _____
Home Cell Work

Family Physician _____ Phone _____

Address _____

Family Dentist _____ Phone _____

Address _____

Hospital Preference _____

PERSONAL MEDICATION NOTIFICATION
and
ACKNOWLEDGMENT OF INJURY RISKS

For my own protection, I the student-athlete will inform the athletic trainer and/or physician/doctor of osteopathy/ physician's assistant/nurse practitioner if I am taking any medication or using any ointment, liniments, balms or have a metal implant in my body BEFORE receiving therapy or treatment of any kind in the training room.

Any combination of the above and deep heat therapy could cause serious complications.

We parents/guardians/ and student-athlete have read and understand the preceding statements and agree to their content.

We parents/guardians and student-athletes are aware that preparation for and participation in interscholastic athletics involves many risks of serious and permanent injury to the student-athlete. We understand and acknowledge the danger of these severe injuries as inherent in physical activity which may involve vigorous physical contact.

We parents/guardians and student-athlete have completely read, fully understand, and voluntarily accept and agree to all of the above terms and conditions.

Student-Athlete's Signature _____

Parent/Guardian Signature _____

Phone_____
Home Cell Work

Date _____

This is the recommendation from Internal journal of Cardiovascular Medicine. In reading this article I understand the risks that my child might have a rare congenital abnormality with his or hers heart that might not be picked up by a school physical exam. If the parent has any questions of the cardiovascular function of their child it is their responsibility to arrange a cardiac work that might include an ECG or echocardiography. I furthermore wave all legal responsibilities of MVCS or its volunteer physicians for any missed physical or cardiac abnormalities that might result in harm of my child.

Parent signature/ date/ Time_____