

Dear Parent / Guardian & Student Athlete,

As we are in mid-summer with the school year fast approaching, the athletic department wanted to touch base with you and remind you of a few important upcoming events.

First off, remember that in order to begin practice and to play sports a student athlete must have a current physical examination. You may go to your own doctor for this but the NMAA physical form must be used during the examination. We will be hosting a free physical examination at the school on July 15 beginning at 1:00 pm till 5:00 pm. A parental consent form must be signed in order for the student athlete to receive a physical at the school.

Other required paperwork in order to participate in sports are:

- A copy of current insurance
- Permission to treat
- Signed concussion statement

All of these things are required to be turned in on the first day of practice in order to participate in practice. Varsity (8th – 12th grade) Football practice will begin on Monday August 8 at 6:00 pm. Varsity football players must attend practice this week in order to be in compliance with NMAA rules on number of practices prior to the first game. Our first game is August 26th. Jr High football practice will begin on Monday August 15 @ 4:00 pm.

We are required to have a pre-season meeting for each season. The Fall season pre-season meeting will be held at the school on Sunday August 14th at 6:30pm. This is only for volleyball and football participation. A basketball pre-season meeting will be announced. A parent/guardian and the student athlete are required to attend this meeting and the student athlete will not be able to continue participation until both parties attend a meeting. The following additional requirements must be met in order to participate and will be required at the pre-season meeting:

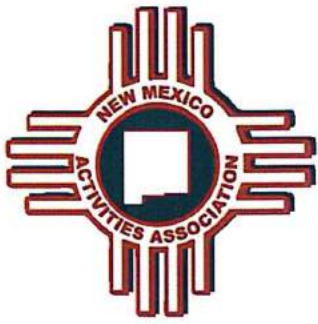
- \$20 athletic participation fee
- Travel release

I hope the summer has been a great break for all of you and that it has been a rewarding time to spend together as a family. I look forward to seeing our kids succeed in all aspects of their lives during this upcoming school year.

Best Regards,
Brandon Devine
Hondo Valley High School
Athletic Director

IMPORTANT DATES

- Sports Physicals – Friday July 15, 1-5pm
- Volleyball Practice – TBA
- Varsity Football Practice – Monday August 8, 6:00 pm
- Fall Sports Pre-Season Meeting – Sunday August 14, 6:30pm
- Jr High Football Practice – Monday August 15, 4:00pm



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 (*Last, First, M.I.*):

Home Address:

Grade:

Street

City

State

Zip

DOB:

AGE:

Name of Parent/Guardian

Home Address:

Phone:

Work:

Street

City

State

Zip

Cell:

Emergency Contact

Phone:

Work:

Name

Relationship

Cell:

Address:

Street

City

State

Zip

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

■ PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines 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

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
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: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> 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?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
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 hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have 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	Yes	No
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 have you 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. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a 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 _____ Signature of parent/guardian _____ Date _____

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■ 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, 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
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, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 			
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 			
Lymph nodes			
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 			
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 			
Neurologic ^c			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider 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



NMAA

New Mexico Activities Association

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 PRESENT

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 SB137

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 137 AND BRAIN INJURIES

Senate Bill 137:

<http://www.nmlegis.gov/Sessions/16%20Regular/final/SB0137.pdf>

For more information on brain injuries check the following websites:

<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, I acknowledge that I have received and reviewed the attached NMAA's *Concussion in Sports Fact Sheet for Athletes and Parents*. I also acknowledge and I understand the risks of brain injuries associated with participation in school athletic activity, and I am aware of the State of the New Mexico's Senate Bill 137; Concussion Law.

Athlete's Signature

Print Name

Date

Parent/Guardian's Signature

Print Name

Date

EMERGENCY MEDICAL AUTHORIZATION FORM

PURPOSE: To enable parents or guardians to AUTHORIZE emergency treatment for children who become ill or injured while under school authority when parents cannot be reached. Upon completion, parents must return this form to Cindy Gomez. The original form and any copies thereof may be used to identify the medical options of the undersigned parent.

Hondo

School District

School Building

Home Room Teacher

Grade

Students Full name:

Last

First

Social Security #

Address:

Street/Road

PO Box

City

State

Zip code

Birth Date

Telephone

Mothers Name	Occupation	Daytime Phone #	Work Phone#	Cell Phone #
Fathers Name	Occupation	Daytime Phone #	Work Phone #	Cell Phone #
Guardian Name	Occupation	Daytime Phone #	Work Phone #	Cell Phone #

Ethnicity:	Hispanic <input type="checkbox"/>	C-Anglo/Caucasian <input type="checkbox"/>	A-Asian or Pacific Islander <input type="checkbox"/>	H-Hispanic <input type="checkbox"/>
	B - Black <input type="checkbox"/>	I-American Indian or Alaskan native <input type="checkbox"/>	Other <input type="checkbox"/>	

Parent/Guardian's

Address

Street

PO Box

City

State

Zip code

ALTERNATE EMERGENCY CNTACTS (Local people to contact if parents cannot be reached)

Name

Phone

Name

Phone

TO GRANT CONSENT

In case of an emergency involving my child and I cannot be reached, I hereby give consent to transport my child to the following medical care providers and hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary:

Doctor

Phone

Dentist

Phone

Nurse Practitioner

/Physician Assistant

Phone

Hospital

Phone

If, for any reason, the above listed medical care providers or hospital cannot be reached, I authorize appropriate transport and medical care of my child to any appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care.

Signature of Parent/Guardian

Date

PLEASE COMPLETE FORM ON OTHER SIDE

Hondo Valley Public Schools
PO Box 55
Hondo, NM 88336

TRAVEL RELEASE FORM

This is to certify that _____
Student Name

has permission to ride **with parents**, after the games for the following events for School
Year 16-17.
Basketball, Football, Volleyball, & Track

I certify that I, _____ am personally transporting my child
from the above stated field trip.

I understand that the Hondo Valley Public Schools require that students ride school transportation to and from all athletic/school sponsored events that the departure from this requirement will release Hondo Valley Public Schools from all liability for any adverse results that may occur. Furthermore, I agree to release the Hondo Valley Public School District and its employees and officers from all liability with reference to the above stated transportation. This form must be on file in the Superintendent's office prior to departure for the event.

Date

Signature of Parent/Legal Guardian

Date

Signature of Superintendent

☐ **APPROVED**

☐ **DENIED**