

ROSWELL INDEPENDENT SCHOOL DISTRICT

ATHLETIC PARTICIPATION AND PHYSICAL EXAM FORMS

School Year 2020-2021

Student: _____

School: _____

Grade: _____

Packet includes:

1. Basic Eligibility Standards and Requirements
2. NMAA Concussion Fact Sheet
 - Parents and Athletes must review and understand risks
 - Parents and Athletes must sign and return signature page with packet to school
3. NMAA Consent to Treat Form
4. Roswell ISD Drug and Alcohol Policy
 - Parents and Athletes must read, understand and sign policy
5. Roswell ISD Drug and Alcohol Testing Consent Form
6. Athlete Information Sheet
 - Parent must fill out and sign.
7. Medical Exam (Physical) Form
 - PARENTS: This physical may be done by your child's Primary Care Provider or at the School Based Health Center (phone number 575-627-2808)
8. NMAA Pre-participation Examination Waiver Form
 - IF PHYSICAL EXAM HAS BEEN COMPLETED IN 19-20 AND ON FILE WITH SCHOOL
9. Clearance Form
 - To be filled out by physician
10. Health Information & Emergency Authorization Form (English and Spanish)
 - Form stays with school nurse

To make appointment at the School Based Health Center call 575-627-2808

**Physical exams completed April 1, 2020 - May 31, 2021 are
valid for the entire 2020 - 2021 school year**

(Per NMAA Eligibility By-Laws 6.15)

Roswell Independent School District Athletics/Activities Office

300 North Kentucky
Roswell, NM 88201

Phone: 575-627-2514

ROSWELL INDEPENDENT SCHOOL DISTRICT

HIGH SCHOOL ELIGIBILITY REQUIREMENTS BASIC ELIGIBILITY STANDARDS

According to New Mexico Activities Association rules you are eligible if you meet each of the following standards:

1. Your parents have signed the parent's consent form stating there are no objections to your participating in athletic contests.
2. You have filed a form with the school indicating you have passed a current physical examination.
3. You are a regularly enrolled student in the 9th, 10th, 11th or 12th grade.
4. You have attended high school, grades 9-12, less than eight (8) semesters.
5. You do not become nineteen (19) years of age before September 1.
6. You passed at least five (5) subjects last grading period, had a 2.0 GPA, and did not fail any classes.
7. You are an amateur that has never received directly, or indirectly, pay or financial benefit for participating in any athletic contest, never signed a contract, or competed under a false name.
8. You have not transferred to or from a private, parochial, or boarding school within 180 school days or 365 calendar days. Always check with your principal before you transfer to determine whether it will affect your eligibility.
9. You have not participated as an individual or as a member of a team other than your school team during the school athletic season without the permission of your principal.
10. You and your parents have a bona fide residence in the school district (attendance area) where you are attending school.
11. You have not accepted any cash or merchandise awards. All awards received must be symbolic in nature with no intrinsic value.

YOU ARE INELIGIBLE IF EACH OF THE ABOVE IS NOT MET.

MIDDLE SCHOOL ELIGIBILITY REQUIREMENTS BASIC ELIGIBILITY STANDARDS

According to New Mexico Activities Association rules you are eligible if you meet each of the following standards:

1. Your parents have signed the parents consent form stating there are no objections to your participating in athletic contests.
2. You have filed a form with the school indicating you have passed a current physical examination.
3. You are a regularly enrolled student in the 7th or 8th grade.
4. You have attended middle school, grades 7 & 8, less than four (4) semesters.
5. You do not become fifteen (15) years of age before September 1.
6. You have not participated in more than two (2) seasons including the current season, in any sport during grades 7 and 8.
7. You passed at least four (4) subjects last grading period, had a 2.0 GPA, and did not fail any classes.
8. You are an amateur that has never received directly or indirectly pay or financial benefit for participating in any athletic contest, never signed a contract, or competed under a false name.
9. You have not transferred to or from a private, parochial, or boarding school within 90 days. Always check with your principal before you transfer to determine whether it will affect your eligibility.
10. You have not participated as an individual or as a member of a team other than your school team during the school athletic season without the permission of your principal.
11. You and your parents have a bona fide residence in the school district (attendance area) where you are attending school.
12. You have not accepted any cash or merchandise awards. All awards received must be symbolic in nature with no intrinsic value.

YOU ARE INELIGIBLE IF EACH OF THE ABOVE IS NOT MET.



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.

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: _____

DRUG AND ALCOHOL PROCEDURE

Athletic and Activities

The Board recognizes the critical importance of its educational mission to promote academic achievement and a safe and secure environment at all campuses in the District.

The sale, distribution, transportation, use of, or possession of alcohol or any type of drug or medication considered illegal or which there is no valid prescription, by any student, participating in extra-curricular activities sponsored by the Roswell Independent School District will result in the suspension from said activities. A student involved in extracurricular activities may not use or have possession of drugs or alcohol (actual or constructive) at any time. The term constructive is defined as being in the company of or any person who is in the sale, distribution, transportation, use of, or possession of alcohol or illegal drugs.

The Board has a strong commitment to the health, safety and welfare of its students. The Board has developed a random drug and alcohol testing program as a reasonably effective means of addressing the District's legitimate concerns in preventing and deterring drug and alcohol use.

Drug and alcohol abuse is one of the most serious problems confronting our society today. Results of studies throughout the United States indicate that education alone, as a preventive measure, is not effective in combating substance abuse. Our commitment to maintaining school-sponsored activities in the District in a safe and secure educational environment requires a clear policy and supportive programs that reasonably relate to prevention and deterrence of substance abuse by students involved in a school-sponsored extracurricular activity.

Based upon careful and extensive research, the Board believes a random drug and alcohol testing program is in the best interest of the District's students for at least the following reasons:

- Use of illegal drugs in a school-sponsored extracurricular activity by students poses a threat to the student's health and safety, as well as to other students.
- To provide students with a legitimate reason to refuse to use illegal drugs and undermine the effects of peer pressure.
- To educate, help, and direct students away from drug and alcohol abuse and toward a healthy and drug-free lifestyle.
- To encourage students who use drugs to seek help by participating in drug treatment programs.
- To ensure that students involved in extracurricular activities set an appropriate example for their fellow students for whom they are often role models.

Participation in a school-sponsored extracurricular activity is a privilege, not a right. This policy applies to all District students in grades seven (7) through twelve (12) who desire to participate in a school-sponsored extracurricular activity at the high school level.

For purposes of this policy, *activity* shall include any extracurricular activity, but not be limited to:

- Any school-sponsored athletic activity; or
- Any school-sponsored club; or
- Any school-sponsored organization such as yearbook, newspaper, student government, drama, music, honor society, or any other organization of a similar nature.

For purposes of this policy, *drugs* shall include, but not be limited to:

- All controlled substances prohibited by law.
- All alcoholic beverages.
- All performance enhancing substances, including but not limited to, anabolic steroids.
- Any prescription or over-the-counter drug, except those for which permission to use in school has been granted pursuant to Board policy.
- Hallucinogenic substances.
- Inhalants.

This random drug testing program is not considered a punitive disciplinary action or considered to imply a violation of the student discipline policies and/or regulations. It is designed to create a safe, drug free environment for students and to assist students in getting help when needed. No student shall be penalized academically, expelled or suspended from school as a result of any verified "positive" test, however, a student will be removed from the activity or position in accordance with Policy. Removal of Students from School-Sponsored Activities.

This random drug testing program does not affect the current policies, practices, or rights of the District pertinent to drug possession or use, where reasonable suspicion is obtained by means other than drug testing through this policy. The District reserves the right to test any student who at any time exhibits cause for reasonable suspicion of drug usage.

Any student involved in an activity whose test is verified "positive" will be subject to the following consequences:

- *First violation:*
 - The student will be suspended from participation in all extracurricular activities for forty-five (45) consecutive school days beginning from the date following the day of verification of a positive test a substantiated violation. The student will not be allowed to attend or participate in practices during this time.
 - The student will be required to fulfill the requirements of his/her class schedule including participation in any classes during the suspension period.
 - If the student is an underclassman the suspension will carry over into the next school year if not completed in the current school year.
- *Second violation:*
 - The student will be suspended from participating in all extracurricular activities for ninety (90) consecutive school days. The term will be reduced to forty-five (45) consecutive school days if the student completes a drug education program at the expense of the student or his/her parent/guardian. The student will not be allowed to attend or participate in practices during this time.
 - The student will be required to fulfill the requirements of his/her class schedule including participation in any classes during the suspension period.
- *Third and subsequent violations:*
 - The student will be suspended from participating in all programs of extracurricular activities for one hundred eighty (180) consecutive school days. The student will not be allowed to attend or participate in practices during this time.
 - The student will be required to attend a drug education program at the expense of the student or his/her parent/guardian as a condition of any further participation in school extracurricular activities.
 - The student will be required to fulfill the requirements of his/her class schedule including participation in any classes during the suspension period.

If the penalty period for any violation is not fulfilled during the season or competition period in which the violation occurred, the remainder of the penalty will be applied to the next extracurricular season or competition period in which the student participates.

Removal from an activity or position is not considered a disciplinary action nor does it imply a violation of the student discipline policies and/or regulations. The principal will follow Policy before removing a student from an activity or position.

STUDENT PLEDGE

I understand the Roswell Independent School District's Athletic and Activity Drug Policy and the consequences if violated.

I pledge:

1. I will not use, or have in my possession, alcohol, drugs or any controlled substance.
2. I will encourage my teammates/classmates to live up to the no-use pledge.

Signature of Student: _____

I will enforce the Roswell Independent School District's Drug/Alcohol policy. I also pledge to inform and, when appropriate, counsel the students concerning the use of alcohol/drugs and consequences.

Signature of Sponsor/Coach: _____

I understand the Roswell Independent School District's Alcohol/Drug Policy and will encourage my son/daughter in their alcohol/drug no-use pledge.

Signature of Parent: _____

ROSWELL INDEPENDENT SCHOOL DISTRICT

STUDENT EXTRA-CURRICULAR ACTIVITIES DRUG/ALCOHOL TESTING CONSENT FORM

School: _____ **Sport:** _____ **M/F:** _____

According to District policy, each student participating in any program of extra-curricular activities shall be provided with a copy of the "Student Extra-Curricular Activities Drug/Alcohol Testing Policy" and the "Student Extra-Curricular Activities Drug/Alcohol Testing Consent Form" which shall be read, signed, and dated by the student and parent or legal guardian before the student shall be eligible to practice or participate in any program of school-sponsored extra-curricular activities. By signing the consent form, the student and parent/guardian consent to the student's providing a sample of urine, saliva, or blood, under the conditions stated in the policy --- by random selection, on the basis of reasonable suspicion, or on the basis of parent/student report --- to be tested for illegal drugs/alcohol. No student shall be allowed to practice or participate in any extra-curricular activities program until the student has returned the properly signed Drug/Alcohol Testing Consent Form.

Student's Last Name	First Name	Middle Name	Student ID #
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I have read the "Student Extra-Curricular Activities Drug/Alcohol Use Testing Policy" and the "Student Extra-Curricular Activities Drug/Alcohol Testing Consent Form" and any questions I have about the Policy or the Consent Form have been answered. I understand the Policy and the Consent Form. I further understand that if I violate the Policy regarding the use of illegal drugs/alcohol, I will be subject to the consequences provided in the Policy.

Signature of Student	Date
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We have read and understand the Roswell Independent School District "Student Extra-Curricular Activities Drug/Alcohol Testing Policy" and the "Student Extra-Curricular Activities Drug/Alcohol Testing Consent Form". We desire that _____ (the Student) participate in extra-curricular activities programs offered by the Roswell Independent School District, and we hereby agree that the Student shall be subject to the terms of the Policy and Consent Form. We understand and agree to the requirements and procedures specified by the Policy, and to all other aspects of the program. We further agree and consent to the reporting of the results of testing as provided in this Policy.

Signature of Parents or Legal Guardian	Date
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Signature of Coach/Athletic Director/Activities Director/Sponsor	Date
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MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

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.



Emergency Information – Parent/Guardian please fill out prior to examination.

Student Athlete Name (Last, First, M.I.):				
Home Address:			Grade:	
<small>Street</small>	<small>City</small>	<small>State</small>	<small>Zip</small>	
DOB:			AGE:	
Name of Parent/Guardian				
Home Address:			Phone:	Work:
<small>Street</small>	<small>City</small>	<small>State</small>	<small>Zip</small>	
Emergency Contact			Cell:	
<small>Name</small>	<small>Relationship</small>	Phone:		
Address:			Work:	
<small>Street</small>	<small>City</small>	<small>State</small>	<small>Zip</small>	
Participant Insurance: Participants must be covered by accident/injury insurance prior to participation.				
Insurance Carrier		Policy Number		Group ID
SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN (CHECK ALL THAT APPLY)				
Sports/Activities				
<input type="checkbox"/> Baseball	<input type="checkbox"/> Cheer	<input type="checkbox"/> Football	<input type="checkbox"/> Softball	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Basketball	<input type="checkbox"/> Cross Country	<input type="checkbox"/> Golf	<input type="checkbox"/> Tennis	<input type="checkbox"/> Wrestling
<input type="checkbox"/> Bowling	<input type="checkbox"/> Dance	<input type="checkbox"/> Soccer	<input type="checkbox"/> Track/Field	<input type="checkbox"/> Other _____
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: 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): _____ How do you identify your gender? (F, M, or other): _____

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		
	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?		

■ 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.

- Medically eligible for all sports without restriction
- Medically eligible for all sports 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

Date: ___/___/___



NMAA 2020-2021 PREPARTICIPATION EXAMINATION WAIVER FORM

*As a result of the COVID-19 pandemic, the following form may be used to waive the annual preparticipation examination requirement for returning Students. This form will only be accepted for the 2020-2021 school year.

NAME (Last, First, MI): _____ AGE: _____ GRADE: _____ DATE OF BIRTH: ___/___/___
SCHOOL: _____ SPORTS: _____
ADDRESS: _____
HOME PHONE: _____ CELL PHONE: _____ OTHER(S): _____

Check YES or NO boxes for each question.

Date of Last Sports Physical
1. Did you receive a preparticipation examination (sports physical) on or after April 1, 2019? YES NO

Medical Risk Questions

- 2. In the last year, has a doctor restricted your participation in sports for any reason without clearing you to return to sports? YES NO
- 3. In the last year, have you passed out or nearly passed out *during or after* exercise? YES NO
- 4. In the last year, have you had discomfort, pain, tightness, or pressure in your chest during exercise? YES NO
- 5. In the last year, has anyone in your immediate family died suddenly and unexpectedly for no apparent reason? YES NO
- 6. In the last year, has any family member or relative died of heart problems or had an unexpected or unexplained death before age 35 (including an unexplained drowning or unexplained car accident)? YES NO
- 7. In the last year, have you had a head injury or concussion that still has symptoms like continuing headaches, concentration problems or memory problems? YES NO
- 8. Have you tested positive for COVID-19? YES NO
- 9. Has anyone in your immediate family tested positive for COVID-19? YES NO
- 10. Have you been in close contact with anyone who has tested positive for COVID-19? YES NO

Parents or Legal Guardians: Please note any health concerns, medications, allergies that may be important for the athletic/activities director and/or coaches to know.

"I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate and I approve participation in athletic activities. Additionally, I am aware that there is an inherent risk of injury and/or illness associated with participation in athletic activity and grant permission for my child to participate in NMAA activities during the current COVID-19 pandemic."

Parent or Legal Guardian Signature

Date

Student Signature

Date

School Personnel Review **For School Use Only**

- 1. Question 1: NO – Student requires a preparticipation examination from an approved HCP using the NMAA-Approved Sports Physical Form: https://www.nmact.org/file/Physical_Form.pdf
- 2. Question 2-4: YES – Student requires a preparticipation examination from an approved HCP using the NMAA-Approved Sports Physical Form: https://www.nmact.org/file/Physical_Form.pdf
- 3. Questions 5-10: YES – Student requires written clearance from an approved HCP.

NOTES:

CLEARED FOR SPORTS: YES NO

CLEARANCE FORM

Athlete Name: _____

Gender: _____

DOB: _____

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Football	Baseball	Cheerleading	Golf
Soccer	Basketball	Dance	
Wrestling	Field	Discus	
	High Jump	Javelin	
	Pole vault	Shot put	
	Softball	Running/Cross Country	
	Volleyball	Strength Training	
		Tennis	
		Track	

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 <input type="checkbox"/> yes <input type="checkbox"/> no	
Immunizations <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> no		Does Athlete require eye protection while playing? <input type="checkbox"/> yes <input type="checkbox"/> no	
Provider's Name: _____		____MD ____DO ____NP ____PA ____DC	Phone: _____
Address:			
Street	City	State	Zip
Signature of Provider: _____		Date: _____	

ROSWELL SCHOOLS HEALTH INFORMATION & EMERGENCY AUTHORIZATION FORM

Gr _____ Teacher _____

PURPOSE: To enable parents/guardians to AUTHORIZE emergency treatment for a child who becomes ill or injured while under school authority, when parents cannot be reached. Upon completion, this form must be returned to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/guardian. **PLEASE COMPLETE ALL THREE SECTIONS!**

Last Name:	First Name:	Middle Initial:	Gender: M F	DOB:
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NAME OF SCHOOL ATTENDED LAST SCHOOL YEAR:

SECTION ONE - STUDENT EMERGENCY CONTACT INFORMATION

In the event your child becomes sick or injured and needs to be sent home or to the ER, the school health office will always attempt to reach the Parent/Guardian listed below FIRST. Secondary contacts will be called if the parent/guardian can not be reached. **PLEASE KEEP THESE NUMBERS CURRENT!**

Parent/Guardian: Check all that apply: <input type="checkbox"/> Lives With <input type="checkbox"/> Legal Guardian	Address:	Phone #1 Phone #2 Phone #3
Parent/Guardian: Check all that apply: <input type="checkbox"/> Lives With <input type="checkbox"/> Legal Guardian	Address:	Phone #1 Phone #2 Phone #3

	Name	Relationship	Phone #1	Phone #2	Phone #3
1.					
2.					
3.					
4.					

Siblings in RISD Schools

	Name	School/Daycare	Grade	DOB
1.				
2.				
3.				

SECTION TWO - STUDENT HEALTH HISTORY - Please check appropriate box

My child has no health conditions including those listed below

Allergies: <input type="checkbox"/> Seasonal <input type="checkbox"/> Food (List):		<input type="checkbox"/> Other Allergy (List):		<input type="checkbox"/> Has EpiPen prescription	
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Congenital/Genetic	<input type="checkbox"/> Ear/Nose/Throat		<input type="checkbox"/> Pulmonary (Other than Asthma)	
<input type="checkbox"/> Asthma Needs Inhaler at School: Y N	<input type="checkbox"/> Eye/Vision Wears glasses/contacts: Y N	<input type="checkbox"/> Diabetes (circle one) Type 1 Type 2		<input type="checkbox"/> Cardiovascular (List) _____ High Blood Pressure: Y N	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Dermatologic/Skin	<input type="checkbox"/> Stomach/GI		<input type="checkbox"/> Musculoskeletal	
Long Term Medications (List):	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Bladder/GU		<input type="checkbox"/> Dental/Oral	
	<input type="checkbox"/> Endocrine Other than Diabetes	<input type="checkbox"/> Hematology/Bleeding Disorders		<input type="checkbox"/> Psychiatric (List Meds):	
<input type="checkbox"/> Any Other Health Conditions:		<input type="checkbox"/> Migraines			

SECTION THREE - INSURANCE INFORMATION

Student's Insurance:	Name of insured parent/guardian:	ID#
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TO GRANT CONSENT

In case of an emergency involving my child AND I CANNOT BE REACHED, I understand emergency medical services will be contacted and my child may be transported to the following provider/hospital for emergency medical care:

Healthcare Provider:	Phone:
Dentist:	Phone:
Hospital:	Phone:

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I give permission for appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless at least two licensed medical providers concur 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. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I give permission to share my child's health information with appropriate school personnel when needed to assure the health, safety, and well-being of my child. I give permission for my child to participate in all school health screenings unless I provide the school health office with a separate written notification requesting exclusion from these screenings. I give permission to administer basic first aid to my child following school protocol including, but not limited, to topical antibiotic ointment, cough drops, eye wash, etc. unless contraindicated.

Parent/Guardian Signature: _____ Date: _____

ESCUELAS DE ROSWELL FORMULARIO DE AUTORIZACIÓN DE SALUD Y EMERGENCIA

Curso _____ Maestro (a)

PROPÓSITO: Permitir a los padres y apoderados el AUTORIZAR tratamiento de emergencia para los niños que se enferman o se hieren mientras están bajo la autoridad de la escuela, cuando los padres no pueden ser localizados. Al completarlo, este formulario debe devolverse a la escuela. El formulario original y otras copias relativas que puedan ser usadas para identificar las opciones médicas aprobadas por los padres y apoderados que firman más abajo. **¡POR FAVOR COMPLETE LAS TRES SECCIONES!**

Apellidos:	Nombre:	Inicial del segundo nombre:	Sexo: M F	Fecha de nacimiento:	
NOMBRE DE LA ESCUELA A LA QUE ASISTIÓ EL AÑO PASADO:					
PRIMERA SECCIÓN – INFORMACIÓN DE CONTACTO EN CASO DE EMERGENCIA DEL ESTUDIANTE					
En caso que su niño (a) se enferme o sea herido(a) y necesite ser enviado a casa o a la emergencia, la oficina de salud de la escuela intentará siempre PRIMERO ubicar a los Padres y Apoderados que aparecen en la lista de abajo. Se llamará a los contactos secundarios si no se logra ubicar a los padres y apoderados. ¡POR FAVOR MANTENGA ESTOS NÚMEROS TELEFÓNICOS AL DÍA!					
Padres/Apoderados: Marque todas las alternativas que apliquen: <input type="checkbox"/> Con quien vive <input type="checkbox"/> Apoderado legal		Dirección:	Teléfono #1	Teléfono #2	Teléfono #3
Padres/Apoderados: Marque todas las alternativas que apliquen: <input type="checkbox"/> Con quien vive <input type="checkbox"/> Apoderado legal		Dirección:	Teléfono #1	Teléfono #2	Teléfono #3
	Nombre	Parentesco	Teléfono #1	Teléfono #2	Teléfono #3
1.					
2.					
3.					
4.					
Hermanos en las escuelas del Distrito Escolar Independiente de Roswell					
	Nombre	Escuela/Jardín de niños	Curso	Fecha de nacimiento	
1.					
2.					
3.					

SEGUNDA SECCIÓN – HISTORIA DE SALUD DEL ESTUDIANTE – Por favor marque la información correspondiente

Mi niño (a) no tiene problemas de salud, tampoco ninguna de las condiciones mencionadas más abajo

Alergias: <input type="checkbox"/> De temporada	<input type="checkbox"/> Alimento (Anótelos):	<input type="checkbox"/> Otras alergias (Anótelas):	<input type="checkbox"/> Tiene receta médica de EpiPen (Auto-inyección de epinefrina)
<input type="checkbox"/> Desorden atencional/Desorden atencional con hiperactividad	<input type="checkbox"/> Enfermedad congénita/Genética	<input type="checkbox"/> Oído/Nariz/Garganta	<input type="checkbox"/> Enfermedad pulmonar (Aparte de asma)
<input type="checkbox"/> Asma Necesita inhalador en la escuela: Sí No	<input type="checkbox"/> Ojos/Vista Usa lentes/lentes de contacto: Sí No	<input type="checkbox"/> Diabetes (marque una) Tipo 1 Tipo 2	<input type="checkbox"/> Enfermedad cardiovascular (Anote) _____ Presión arterial alta: Sí No
<input type="checkbox"/> Cáncer	<input type="checkbox"/> Enfermedad dermatológica/Piel	<input type="checkbox"/> Estómago/Gastrointestinal	<input type="checkbox"/> Enfermedad Músculo esquelética
Medicinas de largo plazo (Anótelas):	<input type="checkbox"/> Desorden alimenticio	<input type="checkbox"/> Vejiga/Tracto urinario	<input type="checkbox"/> Dental/Oral
	<input type="checkbox"/> Enfermedad endocrina distinta de diabetes	<input type="checkbox"/> Hematológicas/Desorden de sangramiento	<input type="checkbox"/> Enfermedad psiquiátrica (Anote las medicinas):
<input type="checkbox"/> Cualquier otras condiciones de salud:		<input type="checkbox"/> Migrañas	

TERCERA SECCIÓN – INFORMACIÓN DE SEGUROS

Seguro de salud del estudiante:	Nombre del padre o apoderado con seguro:	Número de identificación
PARA OTORGAR EL CONSENTIMIENTO		
En caso de una emergencia que afecte a mi niño(a) Y YO NO PUEDA SER UBICADO (A), comprendo que se contactará servicios médicos de emergencia y mi niño (a) será transportado al siguiente proveedor de salud/hospital con atención médica de emergencia:		
Proveedor de salud:	Teléfono:	
Dentista:	Teléfono:	
Hospital:	Teléfono:	

Si por cualquier razón, NI YO NI LOS PROVEEDORES DE SALUD INDICADOS MÁS ARRIBA LOGRAN SER UBICADOS, autorizo para que ser de a mi niño (a) el transporte apropiado a CUALQUIER servicio médico, hospital o establecimiento médico. Esta autorización no cubre cirugía mayor a menos que dos proveedores de salud con licencia médica estén de acuerdo que es necesaria. Ninguna parte de esta sección puede ser utilizada para imponer una responsabilidad a ninguna autoridad escolar o empleado de la escuela, quién en buena fe, trata de cumplir con lo establecido en esta sección. Comprendo que soy financieramente responsable por todos los servicios de emergencia recibidos. Autorizo al personal de salud de la escuela a contactar a los proveedores de salud mencionados más arriba respecto a el manejo médico de mi niño (a). Doy permiso para compartir la información de salud de mi niño (a) con el personal escolar apropiado cuando sea requerido para asegurar la salud, la seguridad, y el bienestar de mi niño (a). Doy permiso para que mi niño (a) participe en todas las pruebas de salud de la escuela a menos que yo provea a la oficina de salud de la escuela con una notificación por escrito aparte que solicite sea excluido (a) de estas pruebas de salud. Doy permiso para que se administre cuidados de primeros auxilios básicos a mi niño (a) siguiendo el protocolo escolar lo que incluye, pero no se limita, a cremas antibióticas tópicas, pastillas para la tos, enjuague para los ojos, etc., a menos que estén contraindicados.

Firma de los padres /apoderados: _____ Fecha: _____