Central Consolidated School District

Sports Pre-Participation Examination

&

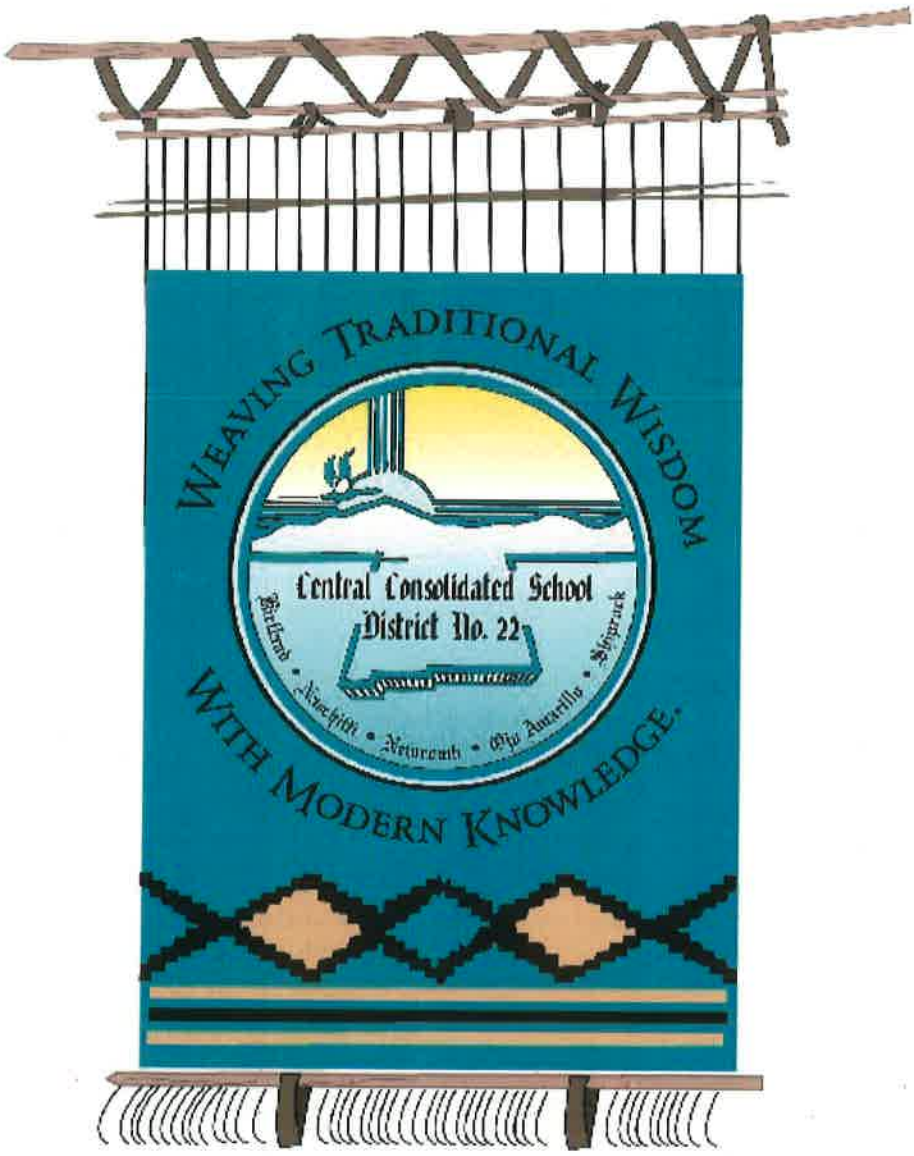
Athletic Information Packet

Student Athlete Name (Print)

Freshman Sophomore Junior Senior

6th 7th 8th

(Circle One)



ELIGIBILITY REQUIREMENTS

1. Pass a physical exam by a licensed physician.
2. Maintain a 2.0 GPA with no more than one **F**, as determined by the 9 weeks grade or the semester grade, which ever is higher.
3. You must be in school the day of a game or the day before a weekend game.
4. When entering a sport, you have five days to determine whether or not to stay with that sport. After the five days, you are locked into that sport for the duration of the season. Only the Head Coach may release the you after that.
5. The use of drugs or alcohol, tobacco, inhalants or any other mind altering substance **will not** be tolerated. Violation will result in an immediate 60 school day suspension during which you will be required to complete a school approved counseling program prior to participation in other extra-curricular activities at CCSD.
6. Unacceptable conduct at school, during athletic events, in the community and surrounding areas will result in discipline. You are representing your school, your community and your family.
7. Unacceptable conduct by your parents/guardians, family members or specific interested parties before, during, and after a game may result in removal, restriction, and/or trespass from subsequent activities on campus per CCSD and NMAA.
8. Your playing time is solely determined by the coaching staff. If there are issues, you are required to follow protocol in seeking resolution.
9. Player ejection from a game, per NMAA, will be as follows:
    - 1st Offense- One game suspension and completion of NFHSLearn Sportsmanship course.
    - 2nd Offense/Subsequent Violations- Two game suspension, attend a meeting with the NMAA Executive Director/designee, additional sanctions as determined by CCSD school officials and approved by the NMAA.

    Please note that ejection suspension includes suspension from participation in practice, warm-ups or other direct involvement.
10. It is a PRIVILEGE **not** a RIGHT to participate in Central Consolidated Schools Athletics. With this privilege comes the responsibility to represent yourself, your parents/guardians, your school and your community with honor, respect and dignity.

AS AN ATHLETE AND PARENT/GUARDIAN, I HAVE READ THE ABOVE REQUIREMENTS AND AGREE TO ALLOW PARTICIPATION IN THE ATHLETIC PROGRAMS AT CENTRAL CONSOLIDATED SCHOOLS.

Athlete (Print)	Athlete Signature/Date
Parent/Guardian (Print)	Parent/Guardian Signature/Date

ImPACT Testing: Baseline ImPACT Testing

1. Baseline ImPACT Testing will be scheduled at least one week *after* practice has started. Scheduled testing will take place prior to final roster posting.
2. Students **not** tested prior to the first scrimmage or game ***will be*** sidelined and listed as ***ineligible***. The baseline ImPACT test is valid for **two years.**
3. The timeline for ImPACT test is unrelated to academic or athletic schedules.
4. The NMAA Concussion Consent Form will be signed by both the student-athlete and parent/guardian prior to administering the test.
5. School Officials (Athletic Director and/or Coaches) are responsible for securing computer labs for baseline ImPACT testing.
6. School Officials will schedule a mutually agreed time with Dr. Waters for baseline testing.
7. Coaches will assist in monitoring their athletes during the testing session.

CCSD Concussion Protocol

1. Bedrest for 48 hours. No electronics or television.
2. Re-evaluation within 24-48 hours
3. Return to school and 504 plan implemented
4. Academics for half day; Audit classes until medically cleared
5. Student-Athlete is not to participate in athletics for ten (10) days. (NMSB137)
6. Impact test to be administered with 48 hours of suspected concussion
7. Student-athlete will be re-evaluated on a weekly basis.

For more information on concussions visit: **http://www.impacttest.com/** *and look for* PACE *(A Dick's Sporting Goods Concussion Awareness Tool)* OR **http://www.cdc.gov/concussion/headsup/** Heads Up: Concussion

Student Athlete (Print Name): _____ Grade: _____

Student Athlete Signature: _____ Date: _____

Parent/Guardian (Print Name): _____

Parent/Guardian Signature: _____ Date: _____

Medical Examination & Medical History Consent Form

(Parent/Legal Guardian)

Please complete the following information:

Student Athlete Name: *(Last, first, MI)*		
DOB:	Age:	Grade:
Mailing Address:		
Physical Address:		
Parent/Guardian:		

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

☐ Baseball	☐ Basketball	☐ Cheer/Drill	☐ Cross Country
☐ Football	☐ Golf	☐ Soccer	☐ Softball
☐ Track	☐ Volleyball	☐ Wrestling	☐ Other_____

_____ Athlete (Print)

_____ Athlete Signature/Date

_____ Parent/Guardian (Print)

_____ Parent/Guardian Signature/Date

Please answer all health history questions on the following page **PRIOR** to your visit to the doctor. Please complete the student-athlete's personal information on each page and return the entire packet to the school's Athletic Department.

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM (Parent/Legal Guardian)

Part A: Health History Form ***Please use the back of the form if necessary for explanations.***

Student-Athlete Name:_____ Gender: _____ DOB: _____

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 (i.e. asthma, diabetes, high blood pressure)? ___Yes ___No
3. Are you currently taking any prescription or over the counter medication? ___Yes ___No
4. Do you have any allergies to medicines, pollen, foods or stinging insects? If yes, please circle
5. Have you ever become dizzy or passed out during or after exercise? ___Yes ___No
6. Have you had chest pain or shortness of breath 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? ___Yes ___No
9. Has a doctor ever told you that you have a heart murmur or "heart trouble"? ___Yes ___No
10. Do you have difficulty breathing during or after exercise? ___Yes ___No
11. Has a doctor ever told you that you have asthma or allergies? ___Yes ___No
12. Do you have a cough that doesn't go away or wheeze or have difficulty breathing during or after exercise? ___Yes ___No
13. Have you ever used an inhaler or taken asthma medicine? ___Yes ___No
14. Have you had a knocked out or passed out after being hit by an object? ___Yes ___No
15. Have you ever had a concussion or hit in the head or after being hit in head complained of: Headache, dizzy spells, feeling confused or difficulty concentrating or forgetful? (please circle one or more)
16. Have you ever been unable to move your arms or legs after being hit or fallen down? ___Yes ___No
17. Have you every had a seizure or convulsions? ___Yes ___No
18. Do you have headaches? If yes, how often?_____ Or Have headaches with exercise? If yes, how often? _____
19. Have you ever had tingling or numbness or weakness in your arms, hands, legs or feet? ___Yes ___No
20. While exercising have you ever had severe muscle cramps or muscle tightness? ___Yes ___No
21. Have you ever suffered from heat illness/heat stroke/passed out while exercising in the heat?___Yes ___No When_____
22. Has a doctor ever ordered a test for your heart (i.e. ECG, echocardiogram)? ___Yes ___No
23. Has anyone in your famiiey died for no apparent reason? ___Yes ___No
24. Has anyone in your family had a heart problem? ___Yes ___No Heart Attack? ___Yes ___No
25. Has a family member or relative died of heart problems or sudden death before the age of 50? ___Yes ___No
26. Have you ever felt like your heart was racing or skipped heartbeats? ___Yes ___No
27. Have you ever had an injury like a sprain, pulled muscle or torn ligament or tendonitis that has caused you to miss a game or practice? Please list: _____ ___Yes ___No
28. Have you had any broken or fractured _ones or dislocated joints? ___Yes ___No
    If Yes, Please list: _____
29. Have you ever had bone or joint injury that required injection, x-rays, MRI, CT? (Please circle one or more)
30. Have you ever had Surgery? ___Yes ___No When? _____ Where? _____
31. Have you ever had to go to: Physical Therapy or Rehabilitation ___Yes ___No
32. Have you ever been fitted with a brace, splint, cast, crutches? ____Yes ____No (If yes, please circle one or more)
33. Have you ever had a stress fracture? __Yes __No. If yes please list location_____
34. Do you reguarly wear a Ace wrap or brace or splint? ___Yes ___No
35. Were you born without or missing a kidney, an eye or testicle or any other organ? ___Yes ___No
36. Have you had a severe viral infection such as infectious mononucleosis (mono) or chronic fatigue? ___Yes ___No
37. Do you have any rashes, or acne or other skin problems? ___Yes ___No
38. Have you had a herpes infection? ___Yes ___No Hepatitis? ___Yes ___No
39. Have you had any problems with your eyes or vision? ___Yes ___No
40. Do you wear glasses or contacts? ___Yes ___No
41. Do you wear protective eyewear such as goggles or a face shield? ___Yes ___No
42. Are you trying to gain or lose weight?
43. Have you ever taken anything to help you build muscle or lose weight? If yes, please list_____
44. Has anyone recommended you change your weight or eating habits? ___Yes ___No
45. Do you have concerns that you would like to discuss with your healthcare provider? ___Yes ___No

Females Only:

46. Have you had a monthly menstual period? ___Yes ___No
47. How old were you when you had your first menstrual period or "monthly? _____
48. Are your menstrual periods 'regular" or every 30 days? __Yes __No
    More frequent? ___Yes ___No Less frequent? __Yes __No
49. Have you ever missed a period? __Yes __No

_____ _____

Parent/Legal Guardian (Print) Parent/Legal Guardian Signature/Date

_____ _____

Primary Care Provider (Print) Primary Care Provider Signature/Date

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM **(Physician Only)**
Part B: Physical Examination

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

Student-Athlete Name:_____ Gender: _____ DOB: _____

BMI %ile____ Pulse ____ Blood Pressure ___/___ Blood Pressure %ile ____ Height _____ Weight _____
(Recheck if elevated ___/___ (per NIH guidelines)

Vison: R20/___ L20/___ Corrected: Y / N Does Athlete wear contacts? Y / N Pupils: Equal ____ Unequal ____
Does Athlete require eye protection while playing? Y / N

Medical	**Normal (Please Circle)**		**Abnormal Findings/Comments**
Appearance	YES	NO	
Eyes/Ears/Nose/Throat	YES	NO	
Hearing	YES	NO	
Lymph Nodes	YES	NO	
Heart (Ascultation should be done supine and standing-abnormal findings require referrel of further evaluation)	YES	NO	
Murmurs	YES	NO	
Pulses	YES	NO	
Lungs: Auscultation	YES	NO	
Abdomen: Assessnent (Incl. liver, spleen)	YES	NO	
Genitourinary	YES	NO	
Skin	YES	NO	
Musculoskeletal	**Normal (Please Circle)**		**Abnormal Findings/Comments**
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	

Notes:_____

_____

_____

_____ _____

Provider's Signature Date

Part B: Clearance Form (Physician Only)

Athlete Name: _____ Gender: _____ DOB: _____

SAMPLES OF CLASSIFICATION OF SPORT BY CONTACT

Contact/Collision	Limited Contact	Non-Contact/Strenuous	Non-Contact/Non Strenuous
Rodeo	Baseball	Discus	Bowling
Football	Cheerleading	Javelin	Golf
Soccer	High Jump	Shot Put	
Wrestling	Softball	Running/Cross Country	
Basketball	Volleyball	Strength Training	
		Track	

Student-Athlete MAY participate in the following types of sports (Check all applicable):

☐ STUDENT CLEARED FOR ALL FORMS OF ATHLETICS

☐ Student Cleared for Participation with no restrictions

☐ Student Cleared with the following restrictions: _____

☐ Student Cleared for Participation PENDING: _____

☐ Student **NOT** Cleared for Participation (Reason): _____

Student-Athlete Emergency Information

Allergies: _____ History of Anaphlaxis? ☐ Yes ☐ No

Immunizations Current? ☐ Yes ☐ No Last Tetanus Immunization: _____

Significant Medical History Information/Current Medical Conditions (*Please include any history of asthma, hypertension, previous head injury, unequal pupil size, etc).*

Physical Performed by: _____ Phone: _____

Address: _____

Provider's Signature: _____ Date: _____

Central Consolidated Schools
Emergency Profile

To Parents/Guardians and Student-Athlete:

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

I hereby give my consent for my child to participate in interscholastic athletics and authorize CCSD to provide the information on the form to the New Mexico Activities Assocation. The financial responsibility for securing care of athletic injuries is a matter between the parent/guardian and the physician/doctor of osteopathy/physician assistant or dentist of parent/guardian's selection. CCSD may not pay doctors, dentists or hospitals for any treatment of any child.

Student-Athlete Name: _____ Student ID Number: _____

Grade: _____ Census #: _____ IHS #: _____

Parent/Guardian: _____

Phone #: _____(Home) _____(Cell) _____(Work)

Mailing Address: _____

Physical Address: _____

Emergency Contacts

Name: _____ Relationship: _____

Phone #: _____(Home) _____(Cell) _____(Work)

Name: _____ Relationship: _____

Phone #: _____(Home) _____(Cell) _____(Work)

Central Consolidated Schools
Emergency Profile
Insurance Information

We have applied for Student Accident Insurance. Please Circle YES NO

Do you go to IHS for primary care? Please Circle YES NO Chart Number: _____

Do you have Medicaid: Please Circle: YES NO ID Number: _____

Insurance Company: _____

Group/Plan Number: _____ Policy Number: _____

Primary Provider's Name: _____ Phone: _____

Address: _____

AUTHORIZATION FOR MEDICAL SERVICES

I request that I be contacted within a resonable time frame in the event of illness or injury requiring medical services. **In the event I cannot be reached, I hereby designate the athletic director, team coach, athletic trainer or their designee to act on my behalf to authorize medical attention, hospitalization and surgery as may be required in an emergency because of illness or injuries sustained by my child while participating in school athletics.** In the event that I cannot be reached and the situation calls for medical attention, I recognize and relinquish our responsibility to the practicing physician or other medical personnel to act in the best interest of my child. I hereby assume financial responsibility for medical attention, hospitalization and surgery.

Allergies

Medication(s) (List): _____ **Insect bites: ___Yes ___No** **Food (List):** _____

Medication(s)

Daily (List): _____ **Asthma Inhaler: ___Yes ___No** **Epi Pen: ___Yes ___No**

_____ _____

Parent/Guardian (Print) Parent/Guardian Signature/Date