Parent(s)/Legal Guardian(s): Read the following statements concerning participation in an Albuquerque Public Schools (APS) interscholastic athletic/extracurricular activity program. A parent/legal guardian is required to review the following information and acknowledge by initialing after each section.

Acknowledgement of Injury Risk: I/we the parent(s)/legal guardian(s) and the named student acknowledge that preparation for and participation in interscholastic athletics involves a risk of serious and permanent injury to a student. We understand and acknowledge the danger of these severe injuries as inherent in the physical activity/contact in all sports.

Initial

Consent to Participate: I/we give consent for the named student to participate in APS interscholastic athletics and/or extracurricular activities as provided by APS and represent the school listed below as a team/group member in accordance with the policies and conditions set forth by the school district, school administration and coaches/sponsors.

Initial

Name of School

List any sports/activities that consent to participate is not given for the named student

Financial Responsibility for Medical Care: It is agreed financial responsibility for securing care of athletic injuries is a matter between the parent(s)/legal guardian(s) and the health care provider. APS will not be liable for payment of health care providers for the treatment of the named student.

Initial

Physical Examinations: Physical exams are required by the New Mexico Activities Association (NMAA) for all athletic participants who wish to participate in tryouts, practices and events. The physical exam must be dated April 1 or later for it to be valid for the following school year. Athletic physical exams dated prior to April 1 of a calendar year will not be valid upon the NMAA starting date for sports in the following school year.

Initial

Consent to Treat: I/we give consent to any supervising coach and/or qualified medical professional (QMP) associated with the APS interscholastic athletic program/extracurricular activity program to arrange for a certified athletic trainer (ATC), EMT or physician to render and provide immediate medical treatment, emergency techniques and/or short/long term treatment to the named student as it relates to injuries that are sustained while participating in such APS sports/activities.

Initial

Notification of Injuries: In order to protect a student at all times, APS athletic trainers will share information concerning the care, disposition and treatment of athletic injuries only with a student’s school athletic trainer, treating physician, team physician, school nurse and team coach on a need to know basis for the time the student is participating at the school. Information released to a third party by school health care providers may only occur with written permission of the parent/legal guardian.

Initial

Concussion Management: A concussion is a disruption in the normal function of the brain that can be caused by a bump, blow or jolt to the head or a penetrating head injury that may occur in any sport or activity. Effects of a concussion may include a variety of symptoms (e.g. headache, nausea, dizziness, memory loss, etc.) with or without loss of consciousness. I/we understand there is a concussion management protocol established that includes extensive care and return to play criteria.

Initial

Transportation Responsibilities: It is agreed that the parent(s)/legal guardian(s) and student will assume the legal responsibilities for the personal safety and action of the named student while traveling to and from practices and games when transportation is not provided by APS. When transportation is provided by APS, policy requires students use such transportation to and from practices and games. Any exceptions must be arranged with the school athletic director/school administration prior to departure and in accordance with athletic travel policy.

Initial
ALBUQUERQUE PUBLIC SCHOOLS

Emergency Contact/Insurance Information

Student Name ____________________________ Date of Birth ________________ Grade ________ School Year __________

Authorization of Health Care Services

I/We designate the team coach or qualified medical professional or his/her designee to act in my/our behalf to authorize such hospitalization, medical attention, surgery, and any other health care services as may be recommended in an medical situation because of illness or injuries while preparing for or participation in interscholastic athletics. Every attempt will be made to make contact with parent(s)/legal guardian(s) prior to making any decision if at all possible without prolonging care for the student. I/We hereby assume all financial responsibility for all health care services provided.

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EMERGENCY CONTACT INFORMATION

<table>
<thead>
<tr>
<th>PARENT/LEGAL GUARDIAN NAME</th>
<th>HOME PHONE</th>
<th>WORK PHONE</th>
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List medications student is taking: ______________________________________________________

List known allergies to medications and/or foods: __________________________________________

List known medical issues: ________________________________________________________________

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Accidental/Health Care Insurance

Accidental/Health insurance is a requirement, prior to tryout, practice, or participation in interscholastic athletics. Insurance can be purchased from a private carrier or from a carrier contracted through APS at a nominal rate. Please contact your school for the application. I/We understand APS does not cover athletic injuries and APS will not assume the financial responsibility for health care services while participation in any school activity/interscholastic athletic program or event.

(NAME OF STUDENT) ____________________________ is covered by accidental/health care insurance.

A □ APS Health/Accident Insurance carrier
   Applied for insurance at ______________________ on ______________________

   SCHOOL ______________________ DATE ______________________

B □ Personal Health/Accident Insurance Carrier ____________________________________________

   NAME OF INSURANCE COMPANY

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I/We the parent(s)/legal guardian(s) and the student have completely read, fully understand and voluntarily accept and agree with all of the above terms and conditions on PAGES 1 AND 2. I/We verify all information is correct.

______________________________  ______________________  ______________________
Parent/Legal Guardian Signature  Date  Relationship

______________________________  ______________________
Student-Athlete Signature  Date

This form shall be with the coach/athletic trainer at all events.
I hereby state that to the best of my knowledge, the answers to the above questions are complete and correct. I understand it is my responsibility as the parent(s)/legal guardian(s) to notify the physician if there are any unique individual problems that are not listed in the above medical history information.

Parent/Legal Guardian Printed ____________________________________________________________________________
Parent/Legal Guardian Signature ____________________________________________________________________ Date __________
Student Name Printed ____________________________________________________________________________
Student Signature ____________________________________________________________________________ Date __________
Student Name __________________________ Date of Birth ____________________ Grade _______ School Year ________

EXAMINATION

Height ________ Weight ________ BMI ________
BP _______ / _______ ( _______ / _______ ) Pulse _______ Vision R 20/ _______ L 20/ _______ Corrected Yes ☐ No ☐ Contacts ☐ Glasses ☐

MEDICAL

NORMAL

ABNORMAL FINDINGS

Appearance
• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)

Eyes/ears/nose/throat
• Pupils equal • Hearing

Lymph nodes

Heart
• Murmurs (auscultation standing, supine, +/- Valsalva)
• Location of point of maximal impulse (PMI)

Pulses
• Simultaneous femoral and radial pulses

Lungs

Abdomen

Genitourinary (males only)

Skin
• HSV, lesions suggestive of MRSA, tinea corporis

Neurologic

MUSCULOSKELETAL

Neck

Back

Shoulder/Arm

Elbow/Forearm

Wrist/Hand/Fingers

Hip/Thigh

Knee

Leg/Ankle

Foot/Toes

Functional
• Duck walk, single leg hop

A Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
B Consider GU exam if in private setting. Having third party present is recommended.
C Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

CLEARANCE FOR PARTICIPATION

☐ CLEARED for all sports without restriction

☐ CLEARED for all sports without restriction with recommendations for further evaluation or treatment (recommendations below as necessary)

☐ NOT CLEARED ☐ pending further evaluation ☐ for any sports ☐ for specific sports (explanation below as necessary)

I have examined and reviewed the medical history of the above named student-athlete and completed the pre-participation physical evaluation. The student-athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the student-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 student-athlete and parent(s)/legal guardian(s).

Name of Physician (print/type) ___________________________________________________________ Date __________

Address __________________________________________________________________________________________ Phone _____________

Signature of Physician ____________________________________________________________________________________________

Adapted from 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society of Sports Medicine, and American Osteopathic Academy of Sports Medicine.
WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

Observed by the Athlete
- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion
- Does not “feel right”

Observed by the Parent / Guardian
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Can’t recall events after hit or fall
- Appears dazed or stunned

WHAT TO DO IF SIGNS/SYMPTOMS OF A CONCUSSION ARE

Athlete
- TELL YOUR COACH IMMEDIATELY!
- Inform Parents
- Seek Medical Attention
- Give Yourself Time to Recover

Parent / Guardian
- Seek Medical Attention
- Keep Your Child Out of Play
- Discuss Plan to Return with the Coach

It’s better to miss one game than the whole season.
Give yourself time to get better. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Second or later concussions can cause damage to your brain. It is important to rest until you get approval from a doctor or health care professional to return to play.
RETURN TO PLAY GUIDELINES UNDER SB38

1. Remove immediately from activity when signs/symptoms are present.
2. Must not return to full activity prior to a minimum of 240 hours (10 days).
3. Release from medical professional required for return.
4. Follow school district’s return to play guidelines.
5. Coaches continue to monitor for signs/symptoms once athletes return to activity.

Students need cognitive rest from the classroom, texting, cell phones, etc.

REFERENCES ON SENATE BILL 38 AND BRAIN INJURIES

Senate Bill 38:

For more information on brain injuries check the following websites:
https://nfhslearn.com/courses/61059/concussion-for-students
http://www.nfhs.org/resources/sports-medicine
http://www.cdc.gov/concussion/HeadsUp/youth.html
http://www.stopsportsinjuries.org/concussion.aspx
http://www.ncaa.org/health-and-safety/medical-conditions/concussions

SIGNATURES

By signing below, parent/guardian and athlete acknowledge the following:

- Both have received and reviewed the attached NMAA’s Concussion in Sports Fact Sheet for Athletes and Parents.
- Both understand the risks of brain injuries associated with participation in school athletic activity, and are aware of the State of the New Mexico’s Senate Bill 38; Concussion Law.
- Athlete has received brain injury training pursuant to Senate Bill 38.

_______________________________   _______________________________   ____________________________
Athlete’s Signature                Print Name                    Date

_______________________________   _______________________________   ____________________________
Parent/Guardian’s Signature       Print Name                    Date