McCurdy Charter School
MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

McCurdy Charter School
PO Box 2250
Espanola, NM 87532
(505) 692-6090
www.mcsk12nm.org

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

☐ Baseball	☐ Football	☐ Cheer/Drill	☐ Wrestling	☐ Bowling
☐Track/Field	☐ Tennis	☐ Volleyball	☐ Golf	☐ Other_____
☐ Cross country	☐ Soccer	☐ Softball	☐ 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

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM
Part A: Health History Form
Student Athlete Name_____ Gender ____ DOB _____

1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	Yes	☐	No	23. Has a doctor ever told you that you have asthma or allergies?	☐		☐	No
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	Yes	☐	No	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	Yes	☐	No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	Yes	☐	No	25. Is there anyone in your family with asthma?	☐	Yes	☐	No
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	Yes	☐	No	26. Have you ever used an inhaler or taken asthma medicine?	☐	Yes	☐	No
5. Have you ever become dizzy or passed out **DURING or AFTER** exercise?	☐	Yes	☐	No	27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ?	☐	Yes	☐	No
6. Have you ever had discomfort, pain, or pressure in your chest during or after exercise?	☐	Yes	☐	No	28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?	☐	Yes	☐	No
7. Do you get more tired than your friends do during exercise?	☐	Yes	☐	No	29. Do you have any rashes, pressure sores or other skin problems?	☐	Yes	☐	No
9. Has a doctor ever told you that you have: ☐High Blood Pressure ☐Heart Murmur ☐Heart Infection ☐High Cholesterol (Check all that apply)	☐	Yes	☐	No	30. Have you had a herpes infection?	☐	Yes	☐	No
					31. Have you had a head injury or concussion?	☐	Yes	☐	No
					32. Have you been hit in the head and been confused or lost your memory?	☐	Yes	☐	No
10. Has a doctor ever ordered a test for your heart?(for example ECG, echocardiogram)	☐	Yes	☐	No	33. Have you ever had a seizure?	☐	Yes	☐	No
11. Has anyone in your family ever died for no apparent reason?	☐	Yes	☐	No	34. Do you have headaches with exercise?	☐	Yes	☐	No
12. Does any one in your family have a heart problem?	☐	Yes	☐	No	35. Have you ever had numbness or tingling or weakness in your arms, or legs?	☐	Yes	☐	No
13. Has a family member or relative died of heart problems or sudden death before the age of 50?	☐	Yes	☐	No	36. Have you ever been unable to move your arms or legs after being hit or fallen?	☐	Yes	☐	No
14. Have any of your relatives ever had any one of the following conditions? Hypertrophic cardiomyopathy, dilated cardiomyopathy, Marfan's syndrome or Long QT Syndrome or a significant heart arrhythmia?	☐	Yes	☐	No	37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	Yes	☐	No
					38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	Yes	☐	No
15. Have you ever had racing of your heart or skipped heartbeats?	☐	Yes	☐	No	39. Have you had any problems with your eyes or vision?	☐	Yes	☐	No
					40. Do you wear glasses or contact lenses?	☐	Yes	☐	No
16. Have you ever spent the night in a hospital?	☐	Yes	☐	No	41. Do you wear protective eyewear such as goggles or a face shield?	☐	Yes	☐	No
17. Have you ever had surgery?	☐	Yes	☐	No	42. Are you unhappy with your weight?	☐	Yes	☐	No
18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? ☐ Yes ☐ No If yes circle affected area below:					43. Are you trying to gain or lose weight?	☐	Yes	☐	No
					44. Has anyone recommended you change your weight or eating habits?	☐	Yes	☐	No
19. Have you had any broken or fractured bones or dislocated joints? ☐ Yes ☐ No If yes circle affected area below:					45. Do you limit or carefully control what you eat?	☐	Yes	☐	No
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? ☐ Yes ☐ No If yes circle affected are below:					46. Do you have concerns that you would like to discuss with the doctor/health care provider?	☐	Yes	☐	No
					FEMALES ONLY: 47. Have you ever had a menstrual period? ☐Yes ☐No 48. How old were you when you had your first menstrual period? _____ 49. How many periods have you had in the last 12 months? _____				

Head	Neck	Shoulder	Upper arm	Elbow	Calf or shin	Hand	Chest
Upper back	Lower Back	Forearm	Thigh	Knee	Hip	Ankle	Foot Toes

21. Have you ever had a stress fracture?	☐	Yes	☐	No
22. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?	☐	Yes	☐	No
23. Do you regularly use a brace or assistive device?	☐	Yes	☐	No

Explain "Yes" answers here (*use the back of the form if necessary):*

_____
_____
_____
_____
_____
_____

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

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

Student Athlete Name *(Last, First, M.I.):* **DOB:**	**Height** _____	**Weight:** _____
BMI %ile____ *(Per CDC %ile charts)* **Pulse:** _____	**Blood Pressure:** _____/____ **(***Recheck if elevated***)** _____/____ _____/_____	**Blood Pressure %ile**_____ *(per NIH guidelines)*
Vision: R20/___L20/ ____Corrected: Y / N	Pupils : Equal _____Unequal_____	

MEDICAL	**Normal** (*circle one*)		**Abnormal Findings/Comments**
Appearance	YES	NO	
Eyes/Ears/Nose/Throat	YES	NO	
Hearing	YES	NO	
Lymph nodes	YES	NO	
Heart (*auscultation should be done supine and standing- abnormal findings require referral for further evaluation)*	YES	NO	
Murmurs	YES	NO	
Pulses	YES	NO	
Lungs: Auscultation	YES	NO	
Abdomen: Assessment (*incl. liver, spleen)*	YES	NO	
Genitourinary (*males only)*	YES	NO	
Skin	YES	NO	
MUSCULOSKELETAL			
Neck	YES	NO	
Back	YES	NO	
Shoulder/Arm	YES	NO	
Elbow/Forearm	YES	NO	
Wrist/Hand/Fingers	YES	NO	
Hip/Thigh	YES	NO	
Knee	YES	NO	
Leg/Ankle	YES	NO	
Foot/Toes	YES	NO	

NOTES:_____

_____

Does Athlete wear contacts? ☐ Yes ☐ No
Does Athlete require eye protection while playing? ☐ Yes ☐ No

Student MAY participate in the following types of sports (CHECK ALL THAT APPLY):
☐ **ALL FORMS OF SPORTS** ☐ CONTACT/COLLISION ☐ NON-CONTACT/STRENUOUS
☐ LIMITED CONTACT ☐ NON-CONTACT/NON-STRENUOUS
☐ STUDENT CLEARED FOR PARTICIPATION
☐ STUDENT CLEARED FOR PARTICIPATION PENDING _____
☐ STUDENT NOT CLEARED FOR PARTICIPATION
Name of Physician/Provider (print/type) _____ Date_____

Signature of Physician /Provider _____

Student's Primary Physician/Provider (for follow up, if necessary):_____

CLEARANCE FORM

Athlete Name: _____ **Gender** _____**DOB** _____

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	**Limited Contact**	**Non-Contact**	
		Strenuous	**Non-strenuous**
Field Hockey	Baseball	Discus	Bowling
Football	Basketball	Javelin	Golf
Ice Hockey	Cheerleading	Shot put	
Lacrosse	Diving	Rowing	
Soccer	Fencing	Running/Cross Country	
Wrestling	Field	Strength Training	
	High Jump	Swimming	
	Pole vault	Tennis	
	Gymnastics	Track	
	Skiing		
	Softball		
	Volleyball		

Student MAY participate in the following types of sports: (CHECK ALL THAT APPLY)

☐ **STUDENT CLEARED FOR ALL FORMS OF SPORTS**

☐ CONTACT/COLLISION ☐ NON-CONTACT/STRENUOUS ☐ LIMITED CONTACT ☐NON-CONTACT/NON-STRENUOUS

☐ **STUDENT CLEARED FOR PARTICIPATION**

☐ **STUDENT CLEARED FOR PARTICIPATION PENDING:** _____

☐ **STUDENT NOT CLEARED FOR PARTICIPATION**

STUDENT ATHLETE EMERGENCY INFORMATION

ALLERGIES_____ **HISTORY OF ANAPHYLAXIS?** ☐ Yes ☐ No

IMMUNIZATIONS ☐Up to date Last Tetanus Immunization _____

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

Student's Primary Physician/Provider *(For follow up, if necessary*):_____

Current Medical Conditions:

Current Medications(*if on asthma medication please indicate if needed prior to sports*)**:**

Does Athlete wear contacts? ☐ Yes ☐ No **Does Athlete require eye protection while playing? ☐ Yes ☐ No**

Providers Name		**___MD___DO____NP___PA___DC**	**Phone:**
Address:			
Street	*City*	*State* *Zip*	
Signature of Provider			**Date:**

Last updated 3/28/2014