Mesilla Valley Christian Schools

MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

Note to Parents/Guardians: In order that the best plans may be made for your child, it is necessary that we have your cooperation in filling out this questionnaire accurately and the school must have this form on file before he/she can participate in the first practice session and in interscholastic competition sports (NMAA and SWCAA). Physicals are only good for the current school year.

Medical History (Parent or Guardian please fill out prior to examination)

Name of Student _____ Grade _____

Date of Birth _____ Age _____

Home Address _____

Name of Parent/Guardian _____

Home Address _____

Phone: Home _____ Cell _____ Office _____ Emergency _____

After conferring with your child, please initial after each sport in which you permit him/her to participate.

Baseball	Cheerleading	Volleyball
Basketball	Golf	Cross Country
Football	Swimming/Diving	Other _____
Tennis	Softball	

Do you want to talk to a physician/doctor of osteopathy/physician's assistant/nurse practitioner about a health problem or injury? Yes ☐ No ☐

	Yes	No
Has anyone in your immediate family ever had:		
Diabetes?	☐	☐
Allergies - hay fever or asthma?	☐	☐
Migraine Headaches?	☐	☐
Heart Condition?	☐	☐
High Blood Pressure?	☐	☐
Has anyone in your family under age 50 died suddenly?	☐	☐
Have you had or do you now have:		
Brain concussion - head injury?	☐	☐
Tendency to lose consciousness?	☐	☐
Skull fracture?	☐	☐
Convulsions or epilepsy?	☐	☐

	Yes	No
Have you had or do you now have:		
Poor vision in one eye?	☐	☐
Temporary loss of vision?	☐	☐
Wear glasses or contact lenses?	☐	☐
Have you had or do you now have:		
Hearing loss?	☐	☐
Perforated eardrum	☐	☐
Recurrent infections?	☐	☐
Sinus infections?	☐	☐
Broken nose?	☐	☐
Dental plate?	☐	☐
Orthodontia?	☐	☐
Have you had or do you now have:		
Hernia?	☐	☐
Kidney Problems?	☐	☐
Boys - Absence of testicles?	☐	☐
Girls - Menstrual problems?	☐	☐
Age of onset of menstruation _____		
Have you had or do you now have:		
Bone fracture?	☐	☐
Joint dislocation?	☐	☐
Foot problems?	☐	☐
Pins, staples or wires in any part of your body?	☐	☐
Have you had or do you now have:		
Back injury or frequent headaches?	☐	☐
Knee injury (sprain) or recurrent pain?	☐	☐
Ankle injury (sprain) or recurrent pain?	☐	☐
Other joint problems?	☐	☐
Bone infection?	☐	☐
Have you had or do you now have:		
Diabetes - High blood sugar in blood or urine?	☐	☐
Tendency to bleed or bruise easily?	☐	☐
Anemia?	☐	☐
Weight problems - Under weight or over weight?	☐	☐
Have you had or do you now have:		
Asthma?	☐	☐
Hay fever?	☐	☐
Hives or rash?	☐	☐
Bee sting reactions (allergy)?	☐	☐
Reaction or medication (allergy)?	☐	☐
Do you:		
Smoke?	☐	☐
Take any medication regularly?	☐	☐
If yes, name of medication _____		

	Yes	No
Have you had or do you now have:		
Heart murmur or other heart condition?	☐	☐
High blood pressure?	☐	☐
Persistent cough?	☐	☐
Chest pain with exercise?	☐	☐
Dizziness or faintness with exercise?	☐	☐
Have you had or do you now have:		
Recurrent rash?	☐	☐
Fungus infection?	☐	☐
Athlete's foot?	☐	☐
Recurrent boils - skin infection?	☐	☐
Do you wish to discuss an emotional problem with the Physician/doctor of osteopathy/physician's assistant/nurse practitioner?	☐	☐
Have you ever been told to give up sports because of the Heath problems?	☐	☐

Medical Examination

Licensed Medical Physician/Doctor of Osteopathy/Physician's Assistant/Nurse Practitioner only, as per NMAA Handbook, 4.16

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Eyes Uncorrected R 20/ _____ L 20/ _____

Eyes Corrected R 20/ _____ L20/ _____

	NORMAL	ABNORMAL	REMARKS
EENT			
Cardiovascular			
Abdomen			
Hernia			
Genitalia			
Musculoskeletal			
Neurological			
Deformities			
Surgical Scars			
Skin			
Urinalysis			

I certify that I have on this date reviewed the above history and examined this individual and find him/her physically able to compete in interscholastic athletics.

PRINT _____
Examining Licensed Medical Physician/Doctor of Osteopathy/Physician's Assistant/Nurse Practitioner

SIGNATURE _____
Examining Licensed Medical Physician/Doctor of Osteopathy/Physician's Assistant/Nurse Practitioner

ADDRESS _____
Street City State Zip

PHONE _____

DATE _____

COMMENTS:

To Parent/Guardian and Student Athlete

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

Insurance

Insurance Provider _____

Insurance Phone Number _____

Insurance Policy Number _____

PARENTAL CONSENT

I hereby give my consent for _____ to participate in interscholastic athletics at Mesilla Valley Christian Schools. The financial responsibility for securing care of athletic injuries is a matter between the parent/guardian and physician/doctor of osteopathy/physician's assistant or dentist of parent's/guardians selection. Mesilla Valley Christian Schools may not pay doctors, dentists or hospitals for any treatment of any child.

MEDICAL HISTORY

I hereby state that I have reviewed the medical history of my child and find the answers to the questions correct to the best of my knowledge.

AUTHORIZATION FOR MEDICAL SERVICES

The Parents/Guardians request that I/we be contacted within a reasonable time in the event of illness or injury requiring medical service. In the event I/we cannot be reached, the Parents/Guardians hereby designate the Athletic Director, Team Coach, Athletic Trainer or their designee to act in my/our behalf to authorize such hospitalization, medical attention and surgery as may be required in an emergency because of illness or injuries sustained by my/our child/ward while participating in school athletics. In the event I/we cannot be reached, and the situation calls for medical attention, I/we recognize and relinquish my/our responsibility to a practicing physician/doctor of osteopathy/physician's assistant and/or medical personnel acting in the best interest of my/our child/ward. I/We hereby assume financial responsibility for hospitalization, medical attention and surgery provided.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Phone _____
Home Cell Work

Family Physician _____ Phone _____

Address _____

Family Dentist _____ Phone _____

Address _____

Hospital Preference _____

PERSONAL MEDICATION NOTIFICATION
and
ACKNOWLEDGMENT OF INJURY RISKS

For my own protection, I the student-athlete will inform the athletic trainer and/or physician/doctor of osteopathy/ physician's assistant/nurse practitioner if I am taking any medication or using any ointment, liniments, balms or have a metal implant in my body BEFORE receiving therapy or treatment of any kind in the training room.

Any combination of the above and deep heat therapy could cause serious complications.

We parents/guardians/ and student-athlete have read and understand the preceding statements and agree to their content.

We parents/guardians and student-athletes are aware that preparation for and participation in interscholastic athletics involves many risks of serious and permanent injury to the student-athlete. We understand and acknowledge the danger of these severe injuries as inherent in physical activity which may involve vigorous physical contact.

We parents/guardians and student-athlete have completely read, fully understand, and voluntarily accept and agree to all of the above terms and conditions.

Student-Athlete's Signature _____

Parent/Guardian Signature _____

Phone_____
Home Cell Work

Date _____

This is the recommendation from Internal journal of Cardiovascular Medicine. In reading this article I understand the risks that my child might have a rare congenital abnormality with his or hers heart that might not be picked up by a school physical exam. If the parent has any questions of the cardiovascular function of their child it is their responsibility to arrange a cardiac work that might include an ECG or echocardiography. I furthermore wave all legal responsibilities of MVCS or its volunteer physicians for any missed physical or cardiac abnormalities that might result in harm of my child.

Parent signature/ date/ Time_____