ROSWELL INDEPENDENT SCHOOL DISTRICT

ATHLETIC PARTICIPATION AND PHYSICAL EXAM FORMS

School Year 2022-2023

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. Clearance Form
   - To be filled out by physician
9. 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, 2022 - May 31, 2023 are valid for the entire 2022 - 2023 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.*

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:
https://www.nmlegis.gov/Sessions/17%20Regular/final/SB0038.pdf

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

NEW MEXICO ACTIVITIES ASSOCIATION
6600 PALOMAS AVE. NE
ALBUQUERQUE, NM 87109
PHONE: 505-923-3110
FAX: 505-923-3114

www.nmact.org

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 are 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 #

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

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

Signature of Coach/Athletic Director/Activities Director/Sponsor Date

ROSWELL INDEPENDENT SCHOOL DISTRICT
ATHLETE INFORMATION SHEET

Name	**Home address**	**School**
Birth Place	**Date of Birth/Age**	**Emergency Telephone**
Family Physician	**Address**	**Telephone**
List any medical problems or allergies student has:		

INSURANCE COVERAGE, EITHER FAMILY OR SCHOOL OFFERED, IS MANDATORY. Please check one of the following:

_____Family Insurance **_____ School Insurance**

Medical and Hospitalization Insurance information:

Company Name	Policy Number

By signing this form, I certify the following:

1. The student named above has my approval to participate in interscholastic athletics.
2. This student has my consent to travel with the representative of the school on trips necessary for this competition.
3. The above-named student does reside with me at the address listed above as the student's home address, in keeping with the RISD and Athletic policy governing athletic eligibility within this district. I confirm that the above-named student is attending the appropriate school within the attendance zone in which he/she lives. If our residence changes, we will make the appropriate change in schools.
4. I understand that falsification of this information may result in the student being ineligible in all sports for 365 days of 24 hours each from the date of the discovery of the false information. This is in accordance with New Mexico Activities Association's policy concerning student eligibility.
5. I understand and will comply with the medical and insurance requirements for the student's participation in interscholastic sports. In the event he or she is injured, you are authorized to render first aid and/or secure medical treatment from the physician named above, or if injury occurs outside of Roswell, you are to secure qualified medical treatment from a physician or facility in the area.
6. I, as a parent, and my son/daughter, as a student athlete, are aware that preparation for and participation in interscholastic athletics involves many risks that could result in 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.

   Student athletes competing in RISD athletic programs are covered by a catastrophic accident medical policy provided by the RISD in the event medical bills for an athlete injured in the RISD athletic program should exceed $10,000.00.

   I have read completely, fully understand, voluntarily accept and agree to all of the above terms and conditions.

   Parent or Legal Guardian: _____ Signature: _____

   Address: _____ Phone No: _____

   HIGH SCHOOL/MIDDLE SCHOOL COACH'S STATEMENT: As the coach of the student named above I hereby verify that the address given as the student's and parent's home address is within the attendance boundaries of the school which this student attends.

   Signature of Coach: _____

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:	
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*		

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

☐ Baseball	☐ Cheer	☐ Football	☐ Softball	☐ Volleyball
☐ Basketball	☐ Cross Country	☐ Golf	☐ Tennis	☐ Wrestling
☐ Bowling	☐ Dance	☐ Soccer	☐Track/Field	☐ 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.

COVID-19 ACKNOWLEDGEMENT

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.

_____ Student-Athlete Signature

_____ Date

_____ Parent or Court Appointed Legal Guardian Signature

_____ Date

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

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): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots

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?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. 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?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N

COVID-19 VACCINE
Previously received COVID-19 vaccine: ☐ Y ☐ N
Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (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 • 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

C L E A R A N C E F O R M

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 ❑ 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	
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:

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:	Address:	Phone #1
		Phone #2
Check all that apply: □ Lives With □ Legal Guardian		Phone #3
Parent/Guardian:	Address:	Phone #1
		Phone #2
Check all that apply: □ Lives With □ Legal Guardian		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: □ Seasonal	□ Food (List):	□ Other Allergy (List):	□ Has EpiPen prescription
□ ADD/ADHD	□Congenital/Genetic	□ Ear/Nose/Throat	□ Pulmonary (Other than Asthma)
□ Asthma Needs Inhaler at School: **Y N**	□ Eye/Vision Wears glasses/contacts: **Y N**	□ Diabetes (circle one) Type 1 Type 2	□ Cardiovascular (List)_____ High Blood Pressure: **Y N**
□ Cancer	□ Dermatologic/Skin	□ Stomach/GI	□ Musculoskeletal
Long Term Medications (List):	□ Eating Disorder	□ Bladder/GU	□ Dental/Oral
	□ Endocrine Other than Diabetes	□ Hematology/Bleeding Disorders	□ Psychiatric (List Meds):
□ Any Other Health Conditions:		□ Migraines	

SECTION THREE - INSURANCE INFORMATION

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

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: _____

Revised 3/31/16

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: □ Con quien vive □ Apoderado legal	Dirección:	Teléfono #1 Teléfono #2 Teléfono #3
Padres/Apoderados: Marque todas las alternativas que apliquen: □ Con quien vive □ 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: □ De temporada	□ Alimento (Anótelos):	□ Otras alergias (Anótelas):	□ Tiene receta médica de EpiPen (Auto-inyección de epinefrina)

□ Desorden atencional/Desorden atencional con hiperactividad	□ Enfermedad congénita/Genética	□ Oído/Nariz/Garganta	□ Enfermedad pulmonar (Aparte de asma)
□ Asma Necesita inhalador en la escuela: **Sí No**	□ Ojos/Vista Usa lentes/lentes de contacto: **Sí No**	□ Diabetes (marque una) Tipo 1 Tipo 2	□ Enfermedad cardiovascular (Anote)_____ Presión arterial alta: **Sí No**
□ Cáncer	□ Enfermedad dermatológica/Piel	□ Estómago/Gastrointestinal	□ Enfermedad Músculo esquelética
Medicinas de largo plazo (Anótelas):	□ Desorden alimenticio	□ Vejiga/Tracto urinario	□ Dental/Oral
	□ Enfermedad endocrina distinta de diabetes	□ Hematológicas/Desorden de sangramiento	□ Enfermedad psiquiátrica (Anote las medicinas):
□ Cualesquiera otras condiciones de salud:		□ 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: _____