Dear Parents/Guardians:

The Springer School strives to provide the best possible athletic programs for its students. It wants athletic participation to be a valuable educational experience at all levels. You are requested to read the following carefully and thoroughly, discuss its contents with your child and present it to your family physician for his or her approval. This form is to be fully completed and filed at the school BEFORE your child will be allowed to practice and/or compete. We require this physical examination to insure that your child is physically able to participate in athletics and in the event an accident should occur, that we may notify you in a relatively short period of time.

1. PARENTAL CONSENT:
   We want to be sure you consent to your child's participation in interscholastic athletics; therefore, it is necessary that you and your child carefully read and understand the contents of this form along with the expectations of the sport.

2. MEDICAL HISTORY AND EXAMINATION:
   This questionnaire provides a means for the physician/doctor of osteopathy/physician's assistant/nurse practitioner to make reference to previous injury, illness or congenital disorder and also to provide the best possible physical exam for the student athlete.

3. MEDICAL AUTHORIZATION:
   This section provides information to the school for quick reference regarding notification in an emergency situation. Also, it authorizes medical attention in the event parents cannot be reached.

4. INSURANCE:
   The financial responsibility for securing care of athletic injuries is a matter between the parent/guardian and physician/dentist of the parent's selection. It is because of this the Springer School must have on file the insurance your family has to cover your child in case of an accident. The Springer Schools offers Student Accident insurance. You may wish to enroll in this through the school. This is strictly on a voluntary basis and is not required if you have sufficient coverage through your own family medical plan. We must have either a form asking for your own school policy or the name of the company through which you are insured.

5. ELIGIBILITY:
   Rules governing eligibility are determined by the Springer Municipal Schools and

   The New Mexico Activities Association,
   6600 Palomas NE,
   Albuquerque, NM 87109 (505) 821-1887
   www.nmact.org    email: nmact@swee.com
To Parents/Guardians and Student Athletes

PARENTAL CONSENT

I hereby give my consent for __________________________ to participate in interscholastic athletics and the Springer School and authorize the Springer Municipal Schools to provide the information on the form to the New Mexico Activities Association. The financial responsibility for securing care of athlete’s injuries is a matter between the parent/guardian and physician or dentist of parent’s guardian’s selection. Springer School may not pay doctors, dentists, or hospitals for treatment of any child.

INSURANCE

We have applied for Student Accident Insurance through Springer Schools. Yes No

or

We have accident insurance with __________________________

(Name of Company)

MEDICAL HISTORY

I hereby state that I have reviewed the medical history of my child and fill the answers to the questions correct to the best of my knowledge. (Required for legal minors)

- Has anyone in your family under the age of 50 died suddenly? Yes No

- Have you had or do you now have:
  Brain concussion- head injury? Yes No
  Tendency to lose consciousness? Yes No
  Skull Fracture? Yes No
  Convulsions or epilepsy? Yes No
  Neck injury? Yes No

- Have you had or do you now have:
  Poor vision in one eye? Yes No
  Temporary loss of vision? Yes No
  Wear glasses or contact lenses? Yes No

- Have you had or do you now have:
  Hearing loss? Yes No
  Perforated eardrum? Yes No
  Recurrent infections? Yes No
  Sinus infections? Yes No
  Broken nose? Yes No
  Dental plate? Yes No
  Orthodontia? Yes No

- Have you had or do you now have:
  Hernia? Yes No
  Kidney problems? Yes No
  Boys: Absence of testicles? Yes No
  Girls: Menstrual problems?
  Age of onset

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• Have you had or do you now have:
  Bone fracture?  YES  NO
  Joint dislocation?  YES  NO
  Foot problems?  YES  NO
  Pins, staples or wires on body?  YES  NO

• Have you had or do you now have:
  Back injury or frequent headaches?  YES  NO
  Knee injury or recurrent pain?  YES  NO
  Ankle injury or recurrent pain?  YES  NO
  Other joint problems?  YES  NO
  Bone infection?  YES  NO

• Have you had or do you now have:
  Diabetes – High blood sugar in blood
  Or urine?  YES  NO
  Tendency to bleed or bruise easily?  YES  NO
  Anemia?  YES  NO
  Weight problems (under or over)  YES  NO

• Have you had or do you now have:
  Asthma?  YES  NO
  Hay fever?  YES  NO
  Hives or rash?  YES  NO
  Bee sting reactions (allergy)?  YES  NO
  Reaction to medication (allergy)?  YES  NO

• Do you:
  Smoke?  YES  NO
  Take any medication regularly?  YES  NO
  If yes, name medication ____________________________

• Have you had or do you now have:
  Heart murmur or other heart condition?  YES  NO
  High blood pressure?  YES  NO
  Persistent cough?  YES  NO
  Chest pain with exercise?  YES  NO
  Dizziness or faintness with exercise?  YES  NO

• Have you had or do you now have:
  Recurrent rash?  YES  NO
  Fungus infection?  YES  NO
  Athlete's foot?  YES  NO
  Recurrent boils-skin infection?  YES  NO

• Do you wish to discuss an emotional problem with the physician/doctor of osteopathy/physician's assistant/nurse practitioner?  YES  NO

• Have you ever been told to give up sports because of the health problems?  YES  NO
AUTHORIZED FOR MEDICAL SERVICES

I/We request that I/we be contacted within a reasonable time in the event of illness or injury requiring medical services. In the event we cannot be reached, I/we, parent/guardian(s) hereby designate the Athletic Director, Team Coach, Athletic Trainer or his/her designee to act in my/our behalf to authorize in an emergency because of illness or injuries sustained by my/our child/ward while participation in school athletics. In the event we cannot be reached and the situation calls for medical attention, we recognize and relinquish our responsibility to a practicing physician/ doctor of osteopathy/ physician’s assistant/ nurse practitioner 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.

FAMILY MD/ DO/ PA/NP __________________________________ PHONE # __________________________
ADDRESS __________________________________________________________
FAMILY DENTIST __________________________________ PHONE# __________________________

HOSPITAL PREFERENCE:

PARENT / GUARDIAN TELEPHONE ____________________________________________
WORK# ___________ EMERGENCY # __________________________________________
RESPONSIBLE PERSON: ____________________________________________________
PHONE # ___________________________ WORK# __________________________

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MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

Name of Student ____________________________________________ Grade ______________
Date of Birth ______________________________________________ Age ______________
Home Address _______________________________________________
Name of Parent/Guardian _______________________________________
Home # ______________ Work# ______________ Emergency# ____________

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 before he/she can participate in interscholastic competition sports. After conferring with your child, please initial after each sport in which you permit him/her to participate.

Baseball ______ Basketball ______ Cheer/Drill ______ Cross Country ______
Football ______ Golf ______ Soccer ______ Softball ______
Tennis ______ Track ______ Volleyball ______ Wrestling ______
Other __________________________

Do you want to talk to a physician/doctor or osteopathy/physician’s assistant/nurse practitioner about a health problem or injury? Yes ____ No ___

Has anyone in your immediate family ever had:

Diabetes? _______ Yes ____ No ____
Allergies? _______ Yes ____ No ____
Migraine Headaches? ______ Yes ____ No ____
Heart Condition? ______ Yes ____ No ____
High Blood Pressure? ______ Yes ____ No ____

PERSONAL MEDICATION NOTIFICATION

For my own protection, I the student/athlete, will inform the athletic trainer and/or physician 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 parent(s), guardian(s) and student-athletes have read and understand the preceding statements and agree to their content.

ACKNOWLEDGMENT OF INJURY RISKS

We parent(s)/ Guardian(s) 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 an inherent in physical activity, which may involve vigorous physical contact.

We parent(s)/Guardian(s) and student athlete have completely read, fully understand and voluntarily accept and agree to all of the above terms and conditions.

Date ____________________________

Parent / Guardian Signature _______________________________ 

Parent / Guardian Signature _______________________________

Student Athlete Signature __________________________________

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MEDICAL EXAMINATION

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

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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.

Date of Examination: ________________________________

Print Name: _______________________________________

Examining Licensed Medical Physician/ Doctor of Osteopathy/Physician Assistant/ Nurse Practitioner

Signature: _________________________________________

Examining Licensed Medical Physician/ Doctor of Osteopathy/Physician Assistant/ Nurse Practitioner

Address: _________________________________________

Phone Number: ________________________________