

# 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.

- |                                     |                                       |                                      |
|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Baseball   | <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Volleyball  |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Golf         | <input type="checkbox"/> Other _____ |

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

### Has anyone in your immediate family ever had:

- |                                  | Yes                      | No                       |
|----------------------------------|--------------------------|--------------------------|
| Diabetes?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies - hay fever or asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraine Headaches?              | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Condition?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure?             | <input type="checkbox"/> | <input type="checkbox"/> |

### Has anyone in your family under age 50 died suddenly?

Yes  No

### Have you had or do you now have:

- |                                 |                          |                          |
|---------------------------------|--------------------------|--------------------------|
| Brain concussion - head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Tendency to lose consciousness? | <input type="checkbox"/> | <input type="checkbox"/> |
| Skull fracture?                 | <input type="checkbox"/> | <input type="checkbox"/> |

	Yes	No
<b>Have you had or do you now have:</b>		
Poor vision in one eye?	<input type="checkbox"/>	<input type="checkbox"/>
Temporary loss of vision?	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Have you had or do you now have:</b>		
Hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>
Perforated eardrum	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent infections?	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infections?	<input type="checkbox"/>	<input type="checkbox"/>
Broken nose?	<input type="checkbox"/>	<input type="checkbox"/>
Dental plate?	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontia?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Have you had or do you now have:</b>		
Hernia?	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems?	<input type="checkbox"/>	<input type="checkbox"/>
Boys - Absence of testicles?	<input type="checkbox"/>	<input type="checkbox"/>
Girls - Menstrual problems?	<input type="checkbox"/>	<input type="checkbox"/>
Age of onset of menstruation _____		

<b>Have you had or do you now have:</b>		
Bone fracture?	<input type="checkbox"/>	<input type="checkbox"/>
Joint dislocation?	<input type="checkbox"/>	<input type="checkbox"/>
Foot problems?	<input type="checkbox"/>	<input type="checkbox"/>
Pins, staples or wires in any part of your body?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Have you had or do you now have:</b>		
Back injury or frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Knee injury (sprain) or recurrent pain?	<input type="checkbox"/>	<input type="checkbox"/>
Ankle injury (sprain) or recurrent pain?	<input type="checkbox"/>	<input type="checkbox"/>
Other joint problems?	<input type="checkbox"/>	<input type="checkbox"/>
Bone infection?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Have you had or do you now have:</b>		
Diabetes - High blood sugar in blood or urine?	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to bleed or bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Weight problems - Under weight or over weight?	<input type="checkbox"/>	<input type="checkbox"/>

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



**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.

**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.

**INSURANCE**

We have accident insurance with \_\_\_\_\_ (Name of Company)

Student accident insurance is available through Mesilla Valley Christian Schools but the following regulations apply:

- In case of a sports accident, contact Mrs. Velma Boone's office within 24 hours.
- There is a \$100 deductible fee due.

**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 \_\_\_\_\_

