



Interscholastic Participation Form

2009-2010

Navajo Preparatory School, Inc.

1220 W. Apache Street • Farmington, NM 87401

T: (505) 326-6571 • F: (505) 327-9213

STUDENT INFORMATION

Student Name _____ Date of Birth _____ Age _____ Grade _____

Mailing Address _____
Address City State Zip Code

Parent/Guardian Name _____

Home Phone _____ Cell Phone _____ Cell Phone _____

Work Phone _____ Work Phone _____

Check all sport(s) in which student plans to participate in:

- | | | | |
|--|---|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Football | <input type="checkbox"/> Softball | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Golf – Spring only | <input type="checkbox"/> Team Manager | <input type="checkbox"/> Track |
| <input type="checkbox"/> Cross Country | | | |

PARENTAL/GUARDIAN CONSENT

I hereby give my consent for _____ to participate in interscholastic athletics and authorize Navajo Preparatory School to provide necessary academic information and other eligibility information to the **New Mexico Activities Association (NMAA)**, the organization of schools which establishes eligibility standards.

Acknowledgement 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 as inherent in physical activity and contact in all sports.

Parent/Guardian Signature

Student Signature

AUTHORIZATION FOR MEDICAL SERVICES

I/We understand the coach/school official will make every attempt to contact the parent/guardian within a reasonable time in the event of injury requiring medical service. In the event a parent/guardian cannot be reached, I/We, parent/guardian(s) hereby authorize the appropriate school representative to act in my/our behalf to ensure proper medial attention as may be required due to injury or illness sustained by my child/ward while participating in school athletics. In the event we cannot be reached I/We relinquish my responsibility to medial personnel acting in the best interest of my child/ward.

I understand that financial responsibility for securing care of athletic injuries is a matter between the parent/guardian and physician/doctor of osteopathy/physician's assistant/nurse practitioner/ or dentist of parent's/guardian's selection. **Navajo Preparatory School may not pay doctors, dentists or hospitals for treatment of any child.**

Parent/Guardian Signature

Date

Emergency Contacts

(If parents/guardians cannot be reached.)

CONTACT #1

Name _____ Relationship _____

Home Phone () _____

Cell Phone () _____

Work Phone () _____

CONTACT #2

Name _____ Relationship _____

Home Phone () _____

Cell Phone () _____

Work Phone () _____

Student Name _____ Date of Birth _____ Gender _____

PERSONAL MEDICATION NOTIFICATION

For my own protection, I, the student/athlete, will inform the team coach, 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.)

Student Signature

Date

INSURANCE

Per NMAA Handbook, Section VI – 6.13 Participant Insurance

Participants **must be covered** by accident/injury insurance prior to participation by carrying school-offered insurance or by providing the Athletic Department documentation that they are covered by a private insurance carrier. Navajo Preparatory School, Inc. offers Steven-Myers-Toohey & Co., Inc. for those students who need accident/injury insurance or additional coverage on private medical insurance.

Please attach a copy of the insurance or Medicaid card.

Indian Health Services (IHS)

IHS is not an insurance provider and may not cover treatment expenses if your student is treated at a non-IHS facility (i.e. San Juan Regional Medical Center). Please be aware that parent/guardian may be financial responsible for treatment. The Athletic Department encourages the enrollment of your student in the insurance program provided at the beginning of the school year. The cost of coverage is minimal and there are several different options for coverage.

Navajo Preparatory School, Inc. will transport a student in the case of emergency or illness regardless of "coverage".

Medical History

Parent/Guardian, please fill out prior to medical examination.

Student Name _____ Date of Birth _____ Gender _____

HEALTH HISTORY		Yes	No	Yes	No	
Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have allergies to medicines, pollens, food, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever become dizzy or passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest discomfort, pain or pressure during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is there anyone in your family with asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get more tired than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
Has a doctor ever told you that you have:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you born without or are you missing a kidney, an eye or testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
<i>(If yes, check all that apply.)</i>				Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Murmur			Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Infection	<input type="checkbox"/> High Cholesterol			Have you had a herpes infection?	<input type="checkbox"/>	<input type="checkbox"/>
Has a doctor ever ordered a test for your heart (ECG, echocardiogram)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family ever died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
Does any one in your family have a heart condition starting under the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Has a family member or relative died of heart problems or sudden death before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have any of your relatives ever had any one of the following conditions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had numbness or tingling or weakness in your arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic cardiomyopathy, Marfan's syndrome, Long QT syndrome or a significant heart arrhythmia				Have you ever been unable to move your arms or legs after being hit or fallen?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact or glasses?	<input type="checkbox"/>	<input type="checkbox"/>
<i>(If yes, check affected area below.)</i>				Do you wear protective eyewear such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
<i>(If yes, check affected area below.)</i>				Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a bone or joint injury that required x-rays, CT, MRI, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
<i>(If yes, check affected area below.)</i>				Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder		Do you have concerns that you would like to discuss with the doctor/health care provider?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Elbow	<input type="checkbox"/> Calf/Shin		Females Only:		
<input type="checkbox"/> Hand	<input type="checkbox"/> Chest	<input type="checkbox"/> Upper Back		Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lower Back	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh		How old were you when you had your first menstrual period?	_____	
<input type="checkbox"/> Knee	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot		How many periods have you had in the last 12 months?	_____	
<input type="checkbox"/> Toes						

Explain "yes" answers here _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS VALID AND CORRECT

Student-Athlete Signature

Parent/Guardian Signature

I VERIFY THAT I HAVE REVIEWED THE ABOVE INFORMATION

Physician's Signature

Physical/Clearance Form

Student Name _____ Date of Birth _____ Gender _____

To be filled out by a licensed Medical Physician/Osteopathic physician/Physician's Assistant/Nurse Practitioner as per NMAA Handbook, 6.12.

MEDICAL EXAMINATION

Height _____ Weight _____ Pulse _____ Blood Pressure _____ (_____)

Vision: R: 20/ _____ L: 20/ _____ Corrected: Yes No Pupils: Equal Unequal

Medical	NORMAL	
	Yes	No
Appearance	<input type="checkbox"/>	<input type="checkbox"/>
Eyes/Ears/Nose/Throat (if indicated)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing (if indicated)	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
<i>(auscultation should be done supine and standing – abnormal findings require referral for further evaluation)</i>		
Murmurs	<input type="checkbox"/>	<input type="checkbox"/>
Pulses	<input type="checkbox"/>	<input type="checkbox"/>
Lung: Auscultation	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary (if indicated)	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal	NORMAL	
	Yes	No
Neck	<input type="checkbox"/>	<input type="checkbox"/>
Back	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder/Arm	<input type="checkbox"/>	<input type="checkbox"/>
Elbow/Forearm	<input type="checkbox"/>	<input type="checkbox"/>
Wrist/Hand/Fingers	<input type="checkbox"/>	<input type="checkbox"/>
Hip/Thigh	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Ankle	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Toes	<input type="checkbox"/>	<input type="checkbox"/>

Abnormal Findings/Comments: _____

EMERGENCY INFORMATION

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.)

Current Medications (If on asthma medication, please indicate if needed prior to sports)

Does student wear contacts? Yes No Does student require eye protection while playing? Yes No

STUDENT CLEARANCE

Please check one:

Student Cleared For ALL SPORTS

Student Cleared for the following sports only: (Check all that apply)

- | | | | |
|--|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Football | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Team Manager | <input type="checkbox"/> Javelin |
| <input type="checkbox"/> Baseball/Softball | <input type="checkbox"/> Field Events | <input type="checkbox"/> Discus | <input type="checkbox"/> Shot Put |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Pole Vault | <input type="checkbox"/> High Jump | <input type="checkbox"/> Running (Cross Country/Track) |
| <input type="checkbox"/> Golf | | | |

PROVIDER INFORMATION (Please print or use stamp)

Provider's Name _____ MD DO NP PA

Address _____

Phone _____

Signature of Provider _____

Date _____