



# INTERSCHOLASTIC PARTICIPATION FORM

2011-2012

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         | <input type="checkbox"/> Team Manager | <input type="checkbox"/> Track      |
| <input type="checkbox"/> Cross Country | <input type="checkbox"/> Other: _____ |                                       |                                     |

## 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 medical 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 medical 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 (In case a parent/guardian CANNOT be reached.)

### CONTACT #1

### CONTACT #2

\_\_\_\_\_  
*Name Relationship*

\_\_\_\_\_  
*Name Relationship*

Home Phone ( ) \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Work 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.*

#### **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 EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

(Cover sheet)

New Mexico Activities Association  
6600 Palomas NE  
Albuquerque, NM 87109  
[www.nmact.org](http://www.nmact.org)

**NOTE:** The NMAA Does not need a copy of this form. Please return your school's athletic department.

## Medical History – Parent/Guardian please fill out prior to examination.

|   |                     |              |            |
|---|---------------------|--------------|------------|
| <b>Student Athlete Name</b> ( <i>Last, First, M.I.</i> ): |                     |              |            |
| Home Address:   |                     | Grade:       |            |
| <i>Street</i>   | <i>City</i>         | <i>State</i> | <i>Zip</i> |
| DOB:  |                     | AGE:         |            |
| <b>Name of Parent/Guardian</b>                            |                     |              |            |
| Home Address:   |                     | Phone:       | Work:      |
| <i>Street</i>   | <i>City</i>         | <i>State</i> | <i>Zip</i> |
|   |                     | Cell:        |            |
| <b>Emergency Contact</b>                                  |                     | Phone:       | Work:      |
| <i>Name</i>   | <i>Relationship</i> | Cell:        |            |
| Address:  |                     |              |            |
| <i>Street</i>   | <i>City</i>         | <i>State</i> | <i>Zip</i> |

## SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN (CHECK ALL THAT APPLY)

### Sports/Activities

|  |                                   |                                      |                                     |                                      |
|--|-----------------------------------|--------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Baseball      | <input type="checkbox"/> Football | <input type="checkbox"/> Cheer/Drill | <input type="checkbox"/> Wrestling  | <input type="checkbox"/> Bowling     |
| <input type="checkbox"/> Track/Field   | <input type="checkbox"/> Tennis   | <input type="checkbox"/> Volleyball  | <input type="checkbox"/> Golf       | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cross country | <input type="checkbox"/> Soccer   | <input type="checkbox"/> Softball    | <input type="checkbox"/> Basketball |                                      |

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.

### Concussion Management

A concussion is a disturbance in the function of the brain that can be caused by a blow to the body or head and may occur in any sport or activity. Effects of a concussion may include a variety of symptoms (headache, nausea, dizziness, memory loss, balance problem) with or without a loss of consciousness. I/we understand there is a concussion management protocol established that includes care and return to play criteria.

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Present or Court Appointed Legal Guardian Signature

\_\_\_\_\_  
Date

# ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

## Part A: Health History Form

Student Athlete Name \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_

|  |                          |          |                          |       |   |                          |                          |  |    |
|--|--------------------------|----------|--------------------------|-------|---|--------------------------|--------------------------|--|----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?   | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 23. Has a doctor ever told you that you have asthma or allergies?   | <input type="checkbox"/> |                          | <input type="checkbox"/>   | No |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)?   | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 24. Do you cough, wheeze, or have difficulty breathing during or after exercise?                                    | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?   | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 25. Is there anyone in your family with asthma?   | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?  | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 26. Have you ever used an inhaler or taken asthma medicine?   | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 5. Have you ever become dizzy or passed out DURING or AFTER exercise?  | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ?                      | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 6. Have you ever had discomfort, pain, or pressure in your chest during or after exercise?   | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month? | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 7. Do you get more tired than your friends do during exercise?   | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 29. Do you have any rashes, pressure sores or other skin problems?  | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 9. Has a doctor ever told you that you have:<br><input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Heart Infection <input type="checkbox"/> High Cholesterol<br>(Check all that apply)     | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 30. Have you had a herpes infection?  | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
|  |                          |          |                          |       | 31. Have you had a head injury or concussion?   | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
|  |                          |          |                          |       | 32. Have you been hit in the head and been confused or lost your memory?  | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 10. Has a doctor ever ordered a test for your heart?(for example ECG, echocardiogram)  | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 33. Have you ever had a seizure?  | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 11. Has anyone in your family ever died for no apparent reason?  | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 34. Do you have headaches with exercise?  | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 12. Does any one in your family have a heart problem?  | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 35. Have you ever had numbness or tingling or weakness in your arms, or legs?                                       | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 13. Has a family member or relative died of heart problems or sudden death before the age of 50?   | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 36. Have you ever been unable to move your arms or legs after being hit or fallen?                                  | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 14. Have any of your relatives ever had any one of the following conditions?<br>Hypertrophic cardiomyopathy, dilated cardiomyopathy, Marfan's syndrome or Long QT Syndrome or a significant heart arrhythmia?  | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 37. When exercising in the heat, do you have severe muscle cramps or become ill?                                    | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
|  |                          |          |                          |       | 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?          | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 15. Have you ever had racing of your heart or skipped heartbeats?  | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 39. Have you had any problems with your eyes or vision?   | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 16. Have you ever spent the night in a hospital?   | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 40. Do you wear glasses or contact lenses?  | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
|  |                          |          |                          |       | 41. Do you wear protective eyewear such as goggles or a face shield?  | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 17. Have you ever had surgery?   | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 42. Are you unhappy with your weight?   | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game?<br><input type="checkbox"/> Yes <input type="checkbox"/> No If yes circle affected area below:                       | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 43. Are you trying to gain or lose weight?  | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
|  |                          |          |                          |       | 44. Has anyone recommended you change your weight or eating habits?   | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 19. Have you had any broken or fractured bones or dislocated joints?<br><input type="checkbox"/> Yes <input type="checkbox"/> No If yes circle affected area below:  | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | 45. Do you limit or carefully control what you eat?   | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
|  |                          |          |                          |       | 46. Do you have concerns that you would like to discuss with the doctor/health care provider?                       | <input type="checkbox"/> | Yes                      | <input type="checkbox"/>   | No |
| 20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes circle affected area below: | <input type="checkbox"/> | Yes      | <input type="checkbox"/> | No    | FEMALES ONLY:   |                          |                          |  |    |
|  |                          |          |                          |       | 47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No                  |                          |                          |  |    |
| Head   | Neck                     | Shoulder | Upper arm                | Elbow | Calf or shin  | Hand                     | Chest                    | 48. How old were you when you had your first menstrual period? _____ |    |
| Upper back   | Lower Back               | Forearm  | Thigh                    | Knee  | Hip   | Ankle                    | Foot Toes                | 49. How many periods have you had in the last 12 months? _____       |    |
| 21. Have you ever had a stress fracture?   |                          |          |                          |       | <input type="checkbox"/>  | Yes                      | <input type="checkbox"/> | No   |    |
| 22. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?  |                          |          |                          |       | <input type="checkbox"/>  | Yes                      | <input type="checkbox"/> | No   |    |
| 23. Do you regularly use a brace or assistive device?  |                          |          |                          |       | <input type="checkbox"/>  | Yes                      | <input type="checkbox"/> | No   |    |

Explain "Yes" answers here (use the back of the form if necessary):

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# ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

## Part B: Physical Examination

Athlete Name \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_

TO BE COMPLETED BY THE EXAMINING PHYSICIAN OR PROVIDER -PLEASE COMPLETE BOTH PAGES

Student Athlete Name (Last, First, M.I.): \_\_\_\_\_ DOB: \_\_\_\_\_  
 Height \_\_\_\_\_ Weight: \_\_\_\_\_

BMI %ile \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 (Per CDC %ile charts) (Recheck if elevated) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Blood Pressure %ile \_\_\_\_\_  
 (per NIH guidelines)

Vision: R20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Corrected: Y / N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

| MEDICAL  | Normal (circle one) |    | Abnormal Findings/Comments |
|--|---------------------|----|----------------------------|
|  | YES                 | NO |                            |
| Appearance   | YES                 | NO |                            |
| Eyes/Ears/Nose/Throat  | YES                 | NO |                            |
| Hearing  | YES                 | NO |                            |
| Lymph nodes  | YES                 | NO |                            |
| Heart (auscultation should be done supine and standing- abnormal findings require referral for further evaluation) | YES                 | NO |                            |
| Murmurs  | YES                 | NO |                            |
| Pulses   | YES                 | NO |                            |
| Lungs: Auscultation  | YES                 | NO |                            |
| Abdomen: Assessment (incl. liver, spleen)  | YES                 | NO |                            |
| Genitourinary (males only)   | YES                 | NO |                            |
| Skin   | YES                 | NO |                            |
| <b>MUSCULOSKELETAL</b>   |                     |    |                            |
| Neck   | YES                 | NO |                            |
| Back   | YES                 | NO |                            |
| Shoulder/Arm   | YES                 | NO |                            |
| Elbow/Forearm  | YES                 | NO |                            |
| Wrist/Hand/Fingers   | YES                 | NO |                            |
| Hip/Thigh  | YES                 | NO |                            |
| Knee   | YES                 | NO |                            |
| Leg/Ankle  | YES                 | NO |                            |
| Foot/Toes  | YES                 | NO |                            |

NOTES: \_\_\_\_\_

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

Student MAY participate in the following types of sports (CHECK ALL THAT APPLY):  
 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

Name of Physician/Provider (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Physician /Provider \_\_\_\_\_

Student's Primary Physician/Provider (for follow up, if necessary): \_\_\_\_\_

# CLEARANCE FORM

Athlete Name: \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_

## SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

| Contact/Collision | Limited Contact | Non-Contact           |               |
|-------------------|-----------------|-----------------------|---------------|
|                   |                 | Strenuous             | Non-strenuous |
| Field Hockey      | Baseball        | Discus                | Bowling       |
| Football          | Basketball      | Javelin               | Golf          |
| Ice Hockey        | Cheerleading    | Shot put              |               |
| Lacrosse          | Diving          | Rowing                |               |
| Soccer            | Fencing         | Running/Cross Country |               |
| Wrestling         | Field           | Strength Training     |               |
|                   | High Jump       | Swimming              |               |
|                   | Pole vault      | Tennis                |               |
|                   | Gymnastics      | Track                 |               |
|                   | Skiing          |                       |               |
|                   | Softball        |                       |               |
|                   | Volleyball      |                       |               |

**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

|                |  |        |
|----------------|--|--------|
| Providers Name | _____ MD _____ DO _____ NP _____ PA _____ DC | Phone: |
|----------------|--|--------|

Address:

|        |      |       |     |
|--------|------|-------|-----|
| Street | City | State | Zip |
|--------|------|-------|-----|

|                       |       |
|-----------------------|-------|
| Signature of Provider | Date: |
|-----------------------|-------|



# NMAA

New Mexico Activities Association

## CONCUSSION IN SPORTS

### A Fact Sheet for Athletes and Parents

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#### 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 PRESENT

##### 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 THE SB1

1. Remove immediately from activity when signs/symptoms are present.
2. Must not return to full activity prior to a minimum of one week..
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.

## **REFERENCES ON SENATE BILL 1 AND BRAIN INJURIES**

### **Senate Bill 1:**

[www.nmact.org](http://www.nmact.org)

-or-

<http://legis.state.nm.us/Sessions/10%20Regular/final/SB0001.pdf>

**For more information on brain injuries check the following websites:**

<http://www.nfhs.org/sportsmed.aspx>

[www.cdc.gov/ConcussionInYouthSports](http://www.cdc.gov/ConcussionInYouthSports)

[www.stopsportsinjuries.org/concussion](http://www.stopsportsinjuries.org/concussion)

<http://www.ncaa.org>



## **SIGNATURES**

By signing below, I acknowledge that I have received and reviewed the attached NMAA's *Concussion in Sports Fact Sheet for Athletes and Parents*. I also acknowledge and I understand the risks of brain injuries associated with participation in school athletic activity, and I am aware of the State of New Mexico's Senate Bill 1; Concussion Law.

\_\_\_\_\_  
Athlete's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date