INTERSCHOLASTIC PARTICIPATION FORM
FARMINGTON SECONDARY SCHOOLS

This form must be completed and filed at the school before the student is allowed to practice or compete. **PLEASE COMPLETE EVERY LINE ON THIS FORM –------ PRINT EVERYTHING EXCEPT SIGNATURE.**

Student:_____M/F____ School: TIBBETTS MIDDLE SCHOOL

Today's

Sport(s):_____Grade Level:_____Date:_____

School City and

ID#_____Date of Birth_____/_____/_____State of Birth:_____

Month/ Day/ Year

Parent/Guardian Name:_____ Home Phone:_____

Address:_____Work Phone:_____

Physician:_____Physician Phone:_____

Dentist:_____Dentist Phone:_____

Last Year's School_____Enrolled 8th grade_____/____/_____

Month Day Year

We certify the above is correct:

_____ _____

Parent/Guardian Signature **Student Signature**

Read carefully and thoroughly: This district provides the best possible athletic programs for its students. We strive to make athletic participation a valuable educational experience at all levels. Discuss these contents with your child, complete it fully, and have your physician sign following the physical exam. This form must be completed for any student who intends to participate in interscholastic athletics at any level.

Parental Consent: I hereby give my consent for _____ to participate in interscholastic athletics and authorize the Farmington Schools to provide necessary academic and other eligibility information to the New Mexico Activities Association, the organization of schools which establishes eligibility standards. I understand that financial responsibility for care of athletic injuries is a matter between my physician/dentist and myself. Farmington Schools will not pay doctors, dentists, or hospitals for any treatment of my child.

_____ _____

Parent/Guardian Signature **Date**

Acknowledgement of Injury Risk: We are aware that preparation for and participation in interscholastic athletics involves risk of serious and permanent injury to the student-athlete. We acknowledge and understand the danger of possible severe injuries inherent in physical activity and contact in all sports.

_____ _____

Parent/Guardian Signature **Student Signature**

INSURANCE COVERAGE: I have secured health/accident insurance which I consider sufficient to cover expenses/claims arising from any injury my child may experience while participating on any school athletic team, and will not hold the Farmington Schools responsible for payment of any medical expenses.

Insurance Co._____Policy # _____

We have the following coverage: ( ) 24 hour coverage (not football) ( ) Football
( ) Other sports (not football)

_____ _____
Parent/Guardian Signature **Date**

A COPY OF YOUR INSURANCE CARD MUST BE INCLUDED WITH THIS PHYSICAL.

APPROVAL FOR EMERGENCY MEDICAL SERVICES/TREATMENT: I understand the coach/school official will attempt to contact the parent within a reasonable time in the event of injury requiring medical service. In the event a parent cannot be reached, I authorize the appropriate school representative to act in my behalf to ensure proper medical attention as may be required due to injury or illness sustained by my child while participating in school athletics in the above season(s). If I cannot be reached, I relinquish my responsibility to medical personnel acting in the best interest of my child. I assure financial responsibility for such attention.

_____ _____
Parent/Guardian Signature **Date**

PHYSICIAN STATEMENT I have examined _____and find him/her physically fit to compete in practice and contests for the above sport(s) during the 200____ - 200____ Academic year. The following exception is noted:

_____

_____ _____
Physician Signature **Date**

STUDENT STATEMENTS: I will abide by the training rules set up by the coach and by all rules contained in the school's **Student Handbook** and **Athletic Handbook**. I assume full responsibility for the athletic equipment and uniforms issued to me. I will inform the coach/trainer/medical personnel if I am taking medication, using any ointment, liniment, balm, or have a metal implant in my body *before* receiving therapy or treatment of any kind in the training room.

Are you taking any medication(s)? Identify _____

Are you allergic to any medications(s)? Identify_____

_____ _____
Student Signature **Date**

For additional information contact Tibbetts Middle School 599-8613

MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

Medical History – Parent/Guardian please fill out prior to medical exam by physician.

Student _____

	YES	NO
Do you want to talk to a physician/physician's assistant/nurse practitioner about a health problem or injury?	___	___
Has anyone in your immediate family ever had:		
Diabetes?	___	___
Allergies – hay fever or asthma?	___	__
Migraine headaches?	___	___
Heart Conditions?	___	___
High Blood Pressure?	___	___
Has anyone in your family under age 50 died suddenly?	___	___
Have you had or do you now have:		
Brain concussion – head injury?	___	___
Tendency to lose consciousness?	___	___
Skull fracture?	___	___
Convulsions or epilepsy?	___	___
Neck injury?	___	___
Have you had or do you now have:		
Hearing loss?	___	___
Perforated ear drum?	___	___
Recurrent infections?	___	___
Sinus infections?	___	___
Broken nose?	___	___
Dental plate?	___	___
Orthodontia?	___	___
Have you had or do you now have:		
Hernia?	___	___
Kidney Problems?	___	___
*Boy*s, Absence of testicles?	___	___
Girls, Menstrual problems	___	___
Age of onset of menstruation?_____	___	___
Have you had or do you now have:		
Bone fracture?	___	___
Joint dislocation?	___	___
Foot problems?	___	___
Pins, staples or wires in any part of your body?	___	___

	YES	NO
Have you had or do you now have:		
Back injury or frequent headaches?	___	___
Knee injury (spring) or recurrent pain?	___	___
Ankle injury (spring) or recurrent pain?	___	___
Other joint problems?	___	___
Bone infection?	___	___
Have you had or do you now have:		
Diabetes – High blood sugar in blood or urine?	___	___
Tendency to bleed or bruise easily?	___	___
Anemia?	___	___
Weight problems – Under weight or over weight?	___	___
Have you had or do you now have:		
Asthma?	___	___
Hay fever?	___	___
Hives or rash?	___	___
Bee sting reactions (allergy)?	___	___
Reaction to medication (allergy)?	___	___
Do you:		
Smoke?	___	___
Take any medication regularly?	___	___
If yes, name the medication(s): _____		
Have you had or do you now have:		
Heart murmur or other heart condition?	___	___
High blood pressure?	___	___
Persistent cough?	___	___
Chest pain with exercise?	___	___
Dizziness or faintness with exercise?	___	___
Have you had or do you now have:		
Recurrent rash?	___	___
Fungus infection?	___	___
Athlete's foot?	___	___
Recurrent boils – skin infection?	___	___
Do you wish to discuss an emotional problem with the physician/doctor of osteopathy/ physician's assistant/nurse practitioner?	___	___

Have you ever been told to give up sports because of the health problems?

Student Name_____**Grade**_____

Licensed Medical Physician/Doctor of Osteopathy/Physician's Assistant/Nurse Practioner/Chiropractor only as per NMAA Handbook 4.16. ___ ___

Height_____ Weight_____ Blood Pressure_____ Pulse_____

Eyes Uncorrected R 20/_____ L 20/_____

Eyes Corrected R 20/_____ L 20/_____

	NORMAL	ABNORMAL	REMARKS
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.

PRINT:_____
Examiner's Name

SIGNATURE: _____
Examiner's Signature

ADDRESS: _____

PHONE: _____

DATE OF EXAMINATION: _____