



Viking Athletic Participation Form

Valley High School
 1505 Candelaria Road NW
 Albuquerque, NM 87107-2700
 (505) 345-9021
 Fax (505) 761-8429
www.vhsvikings.com

Parents/Guardians please fill out and send back to Valley HS, attn: Mark Hogan.

Student Athlete Name (Last, First, M.I.):		Id#:	
Home Address:		Grade:	
<small>Street City State Zip</small>			
DOB:	SEX: Male Female	AGE:	
Name of Parent/Guardian			
Home Address:		Phone:	Work:
<small>Street City State Zip</small>			Cell:
Emergency Contact		Phone:	Work:
<small>Name Relationship</small>			Cell:
Address:			
<small>Street City State Zip</small>			

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	<input type="checkbox"/>

Student signature _____ Date _____
 Parent signature _____ Date _____

Student-Athlete Name _____ School ID # _____ Grade _____
School _____ School Year _____
Sport(s) Participation: _____

Albuquerque Public Schools Athletic Participation Requirements

Parent(s)/Legal Guardian(s) and Student-Athlete Participating in Athletics:

PLEASE READ THE FOLLOWING STATEMENTS CONCERNING PARTICIPATION IN AN ALBUQUERQUE PUBLIC SCHOOLS (APS) INTERSCHOLASTIC ATHLETIC PROGRAM AND RESPOND WITH YOUR SIGNATURE(S).

Consent to Participate

Consent is hereby given for the named student to engage in interscholastic athletics as approved by APS and represent _____ as a member.

(name of school)

Please list any sports that consent to participate is not given for the above student: _____

Financial Responsibility for Medical Care

It is agreed that financial responsibility for securing care of athletic injuries is a matter between the parent(s)/legal guardian(s) and the health care provider. APS will not pay health care providers for the treatment of any students.

Transportation Responsibilities

It is further agreed that the parent(s)/legal guardian(s) and student will assume the legal responsibilities for the personal safety and action of the above named student while traveling to and from practices and games when transportation is not provided by APS. When transportation is provided by APS, policy requires students use such transportation to and from. Any exceptions must be arranged with the school prior to departure and in accordance with the athletic travel policy.

Acknowledgement of Injury Risk

We the parent(s)/legal guardian(s) and the student-athlete are aware that preparation for and participation in interscholastic athletics involves a risk of serious and permanent injury to the student-athlete. We understand and acknowledge the danger of these severe injuries as inherent in physical activity.

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. To review the APS established protocol for concussion management, visit the APS athletic website or contact the school athletic trainer for more information.

Notification of Injuries

In order to protect the student-athlete at all times, APS athletic trainers will share information concerning the care, disposition, and treatment of athletic injuries only with the treating physician, team physician, athletic trainer, and coaches on a need to know basis only for the time that the student is in high school. Any information released to third parties by school health providers will be done only with permission of the parent/legal guardian and student.

Physical Examinations

Physical exams are required by the NMAA (6.12) for all athletic, cheer, and dance/drill team participants. The physical exam must be dated April 1 or after for it to be valid for the following school year. Athletic physical exams dated prior to April 1 of a calendar year will not be valid upon the NMAA starting date for sports during that following school year.

Student-Athlete Name _____ Student ID # _____
Last First M.I.

Home Address _____ Grade _____
Street City State Zip

Date of Birth _____ Age: _____
Month/Day/Year

Authorization for Health Care Services

I/We hereby designate the team coach or his/her designee to act in my/our behalf to authorize such hospitalization, medical attention, surgery, and any other health care services as may be recommended in an emergency because of illness or injuries while preparing for or participating in interscholastic athletics. Every attempt will be made to make contact with parent(s)/legal guardian(s) prior to making any decision if at all possible without prolonging care for the student-athlete. I/We hereby assume all financial responsibility for all health care services provided.

Accidental/Health Care Insurance:

Accidental/Health Insurance is a requirement, prior to tryout, practice, or participation in interscholastic athletics. Insurance can be purchased from a private carrier or from a carrier contracted through APS at a nominal rate. Please contact your school for the application. **APS does not cover athletic injuries and will not assume the financial responsibility for health care services.**

_____ is covered for accidental/health care insurance through _____

Student-Athlete Name _____

APS Health/Accident Insurance carrier:
We have applied for such insurance at _____ on _____
School Date

Private Health/Accident Insurance Carrier _____
(Name of Carrier)

EMERGENCY CONTACT INFORMATION

Student-Athlete Name _____	Date of Birth _____	Age _____	
Parent/ Legal Guardian Name _____	Home Phone _____	Work Phone _____	Cell Phone _____
Parent/Legal Guardian Name _____	Home Phone _____	Work Phone _____	Cell Phone _____
Emergency Contact _____	Relationship _____	Phone # _____	

Medication(s) Student-Athlete is Taking: _____

Known Allergies to Medication or Foods: _____

Known Medical Problems: _____

We the parent(s)/legal guardian(s) and the student-athlete have completely read, fully understand, and voluntarily accept and agree with all of the above terms and conditions (pages 1 & 2). We verify all information is correct.

Parent/Legal Guardian Signature _____ Date _____ Relationship _____

Student-Athlete Signature _____ Date _____

This form should be with coach at all events

	<u>Yes</u>	<u>No</u>
32 Have you been hit in the head and been confused or lost your memory?	_____	_____
33 Have you ever had a seizure?	_____	_____
34 Do you have headaches with exercise?	_____	_____
35 Have you ever had numbness or tingling or weakness in your arms or legs?	_____	_____
36 Have you ever been unable to move your arms or legs after being hit or fallen?	_____	_____
37 When exercising in the heat, do you have severe muscle cramps or become ill?	_____	_____
38 Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	_____	_____
39 Have you had any problems with your eyes or vision?	_____	_____
40 Do you wear glasses or contacts?	_____	_____
41 Do you wear protective eyewear such as goggles or a face shield?	_____	_____
42 Are you unhappy with your weight?	_____	_____
43 Are you trying to gain or lose weight?	_____	_____
44 Has anyone recommended you change your weight or eating habits?	_____	_____
45 Do you limit or carefully control what you eat?	_____	_____
46 Do you have concerns that you would like to discuss with the doctor/health care provider?	_____	_____
47 List your last immunizations	_____	_____
Tetanus _____(month) _____(year) MMR _____(month) _____(year) Hepatitis Vac _____(month) _____(year)	_____	_____
Females Only		
48 Have you ever had a menstrual period?	_____	_____
49 How old were you when you had your first menstrual period?	_____	_____
50 How many periods have you had in the last 12 months?	_____	_____

Maturity Statement for Contact Sports

As a parent you should understand that statistics indicate that there may be an increase in the number of injuries in contact sports for those students who are not of a comparable maturity level as other participants. If you feel that your son/daughter might be subject to potential injury because of his/her stage of development, please discuss this with him/her and your doctor.

Personal Medical Notification

For my own protection I, the student-athlete, agree to inform the athletic trainer/coach at my school and/or all health care providers, BEFORE receiving therapy or treatment of any kind if I am taking any drugs, medication, supplement, or using any ointment, liniments, balms, or have an implant in my body. We the parent(s)/legal guardian(s) and student-athlete understand and acknowledge that any combination of the above and certain therapy may cause serious medical problems to the student-athlete. If the student-athlete is under the care of a licensed health care professional, a written course of treatment must be on file with the school.

Explain "Yes" Answers here:

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS VALID AND CORRECT

Student-Athlete Signature

Date

Parent/ Legal Guardian Signature

Date

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAM FORM

PHYSICAL EXAMINATION

Student-Athlete Name _____ Gender _____ DOB _____

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

Vision R 20/ _____ L 20/ _____ Corrected Y _____ N _____ Pupils: Equal _____ Unequal _____

MEDICAL **Normal** **Abnormal** **Findings/Comments**

Appearance
(any physical finding of Marfan's syndrome)
Eyes/Ears/Nose/Throat (if indicated)
Hearing (if indicated)

Heart (auscultation should be done supine and standing- abnormal findings require referral for further evaluation)

Murmurs
Pulses
Lungs: Auscultation
Abdomen:
Genitourinary (only if indicated)
Skin

MUSCULOSKELETAL

Neck
Back
Shoulder/Arm
Elbow/Forearm
Wrist/Hand/Fingers
Hip/Thigh
Knee
Leg/Ankle
Foot/Toes

NOTES: _____

I verify that I have reviewed the Medical History information provided and after exam clear student for the following:

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

ALL FORMS OF SPORTS/ACTIVITIES

CONTACT/COLLISION
Football , Soccer, Wrestling

NON-CONTACT/STRENUOUS
Baseball, Basketball, Cheerleading, Track/Field (High Jump, Pole Vault) Softball, Volleyball.

LIMITED CONTACT NON-CONTACT/NON-STRENUOUS
Track/Field (Discus, Javelin, Shot Put, Running Events) Cross Country, Dance/Drill, Strength Training, Swimming, Tennis, Bowling, Golf

STUDENT CLEARED FOR PARTICIPATION PENDING (explanation)

STUDENT **NOT** CLEARED FOR PARTICIPATION (explanation)

Name of Physician/Provider _____ __MD__ DO__ NP__ PA__ DC

Signature of Provider _____ **Date:** _____

Student's Primary Physician/Provider (for follow up if necessary): _____
 Contact Number _____