

**NEW MEXICO STATE UNIVERSITY INTERCOLLEGIATE ATHLETICS
NEW ATHLETE PRE-PARTICIPATION PHYSICAL EXAMINATION**

Name: _____ Sport: _____ Examination Date: _____

Year of Eligibility: (Circle one) FR SO JR SR Redshirt: (Circle one) YES NO

Birth Date: ____/____/____ SSN: ____-____-____

Current Local Address: _____ State: ____ Zip Code: _____

Phone #: _____ Cell #: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to athlete: _____

PRINT (First, Middle, Last)

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Work #: _____ Cell #: _____

**1. DO NOT PROCEED - REMAINDER OF PAGE 1 TO BE COMPLETED BY SPORTS MEDICINE STAFF
2. CONTINUE TO FILL OUT PAGES 2, 3, AND BEGINNING OF 4
3. READ AND SIGN PAGES 6 AND 7**

PRELIMINARY PHYSICAL EXAM ** (Completed by sports medicine staff ONLY) **

Height: _____ Weight: _____ Blood Pressure: ____/____ Pulse: _____

Eyes: R 20/____ L 20/____ With / Without Correction

Contacts: Y N Glasses: Y N Pupils: R > = < L

PHYSICIAN'S EXAM
Ears: _____
Nose: _____
Throat: _____
Heart: _____

Lungs: _____
Breasts (W): _____
Abdomen: _____
Genitalia (M): _____
Dental: _____
Laboratory Tests: _____

PHYSICIAN'S CLEARANCE
Examination Review Date: ____/____/____
Approved: ____ (No medical reason to disqualify)
Deferred: _____ (See Below)
Not Approved: _____
Recommendations: _____

Physician Signature: _____

Athletic Trainer's Notes: _____

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Name: _____

Sport: _____

MEDICAL HISTORY

ALLERGIES:	HAS ANY BLOOD RELATIVE EVER HAD: (Relationship)	IMMUNIZATIONS: (Give latest dates)
Medications: _____ Food Products: _____ Insect Bites: _____ Environmental: (pollen, pets, etc.) _____	High Cholesterol: _____ Diabetes: _____ Heart Problems: _____ High Blood Pressure: _____ Stroke: _____	Tetanus: _____ Measles: _____ Mumps: _____ Rubella: _____

- Yes No** 1. Have you ever been tested for sickle cell trait?
If "yes" please provide written documentation or date of test and hospital location: _____
- Yes No** 2. Please list any medications, vitamins, or supplements that you are currently taking? (**Including those prescribed by a physician and over the counter**): _____
- Yes No** 3. Have you ever be diagnosed with ASTHMA?
- Yes No** 4. Have you ever experienced any unexpected, and /or unexplained shortness of breath with exercise? Wheezing or Bronchitis?
- Yes No** 5. Have you ever had Heat Fatigue/Heat Exhaustion/Heat Stroke?
If "yes" please explain _____
- Yes No** 6. Have you ever had any problems with your eyes or vision/hearing/kidney (urine)?
If "yes" please explain _____
- Yes No** 7. Have you ever been diagnosed with a major medical illness? (i.e. seizure, anemia, diabetes, thyroid disease, bleeding disorders, hepatitis, mononucleosis, hypertension, pneumonia, ulcers, cancer)?
If "yes" please explain _____
- Yes No** 8. Have you ever been diagnosed with a sexually transmitted disease (STD)?
If "yes" please explain _____
- Yes No** 9. Have you ever been hospitalized overnight?
If "yes" please explain (reason, date, length of stay) _____
- Yes No** 10. Have you ever had surgery?
If "yes" please provide dates and an explanation of the surgery _____
- Yes No** 11. Have you ever been diagnosed with Attention Deficit Disorder (ADD) or Attention Deficit Hyperactive Disorder (ADHD)?
If "yes" please list any medications taken and provide documentation from a physician: _____
- Yes No** 12. Do you have a history of a learning disability?
If "yes" please list any medications taken and provide documentation from a physician: _____

CARDIAC HISTORY

- Yes No** 1. Has anyone in your family suffered a premature (50 years or younger) death or significant disability from a heart condition?
If "yes" please explain _____
- Yes No** 2. Do you know of any close relatives with heart conditions?
If "yes" please explain _____
- Yes No** 3. Have you ever been diagnosed as having a heart Murmur/Heart Disease/Palpitations/Rheumatic Fever?
If "yes" please explain _____
- Yes No** 4. Have you ever been told you have a heart condition?
If "yes" please explain _____
- Yes No** 5. Have you ever experienced any excessive, unexpected and/or unexplained fatigue with exercise? Episodes of fainting during exercise?
If "yes" please explain _____
- Yes No** 6. Have you ever experienced any chest pain or breathing difficulty during exercise?
If "yes" please explain _____
- Yes No** 7. Have you ever undergone any testing on your heart?
If "yes" please explain _____

All statements I have made in the above document are correct, complete and true.

SIGNED _____

DATE ____/____/____

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FEMALE MEDICAL HISTORY

1. What was the date of your last menstrual period? _____ Date ____/____/____
2. How many periods have you had in the last 12 months? _____
Yes No 3. Have you ever skipped a period?
If "yes" please explain How many? _____.....What was the longest time between periods? _____
Yes No 4. Do you normally lose your period during training?
If "yes" please explain _____
Yes No 5. Are you currently on any form of prescribed birth control?
If "yes" please explain (List drug name) _____
Yes No 6. Are you currently satisfied with your weight?
If "yes" please explain _____
Yes No 7. Are you currently on a diet or do you adhere to a specific eating style?
If "yes" please explain _____
Yes No 8. Have you ever been diagnosed with a hernia?
If "yes" please explain _____

MALE MEDICAL HISTORY

- Yes No** 1. Are you currently satisfied with your weight?
If "no" please explain _____
Yes No 2. Are you currently on a diet or do you adhere to a specific eating style?
If "yes" please explain _____
Yes No 3. Have you have been diagnosed with a hernia?
If "yes" please explain _____
Yes No 4. Have you ever had problems with your testicles?
If "yes" please explain _____

HEAD INJURY HISTORY

- Yes No** 1. Have you ever had a head injury, been knocked out, been "Dinged", or had a concussion?
If "yes" how many times? _____
If "yes" please provide a date, a description of each incident, and how much time you missed with each incident starting with most recent _____

Yes No 2. Have you had a hit or blow to the head that caused confusion, prolonged headache, dizziness, or memory problems?
If "yes" how many times? _____
If "yes" please provide a date, a description of each incident, and how much time you missed with each incident starting with most recent _____

Yes No 3. Have you ever had any numbness or tingling in your neck, arms, back, or legs?
If "yes" describe. _____

Yes No 4. Do you have a history of migraines?
If "yes" do you take medication for your migraines, and if so what is the name of the medication? _____

Yes No 5. Do you have a history of frequent, chronic, or regularly occurring headaches?
If "yes" please explain? _____
Yes No 6. Do you have a history of seizures?
If "yes" please explain? _____
Yes No 7. Have you ever taken a pre-injury / baseline head injury test?
If "yes" please indicate the name of test and date which you took it: _____

All statements I have made in the above document are correct, complete and true.

SIGNED _____

DATE ____/____/____

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ORTHOPEDIC EXAMINATION

****Explanations MUST include: month/year of injury, specific body part, right or left side of the body**

- Yes No** 1. Have you ever undergone an orthopedic surgery? *(Include specific procedure done)*
If "yes" please explain _____
- Yes No** 2. Have you ever suffered a broken bone, stress fracture, or dislocation?
If "yes" please explain _____
- Yes No** 3. Have you ever had an X-Ray, MRI, or CT Scan of a bone or joint?
If "yes" please explain _____
- Yes No** 4. Have you ever been given a cast, crutches, cane, splint or sling for an injury?
If "yes" please explain _____
- Yes No** 5. Have you ever had any of the following: shin splints, back problems, scoliosis, knee tendonitis, osgood-schlatter's disease, little-league elbow or shoulder?
If "yes" please explain _____
- Yes No** 6. Have you ever had, or currently have, any injuries or conditions that could cause you to miss a game or practice, or affect you athletic participation?
If "yes" please explain _____

EXAMINER: _____ *(Print Name)*

HEAD / NECK					SURGERIES Yes No				
R	L	SPECIAL TESTS (+ or -)	R	L	ROM (WNL or L)	R	L	Strength Test (0 - 4)	
		Spurling's Test			Neck Forward Flexion			Neck Forward Flexion	
					Neck Lateral Flexion			Neck Lateral Flexion	
					Neck Extension			Neck Extension	
					Neck R Rotation			Neck R Rotation	
					Neck L Rotation			Neck L Rotation	

COMMENTS:

SHOULDERS					SURGERIES Yes No				
R	L	SPECIAL TESTS (+ or -)	R	L	ROM (WNL or L)	R	L	Strength Test (0 - 4)	
		Anterior Drawer			Shoulder Flexion			Shoulder Flexion	
		Posterior Drawer			Shoulder Extension			Shoulder Extension	
		Sulcus Sign			Shoulder Abduction			Shoulder Abduction	
		Apprehension Test			Horizontal Abduction			Horizontal Abduction	
		Speed's Test			Horizontal Adduction			Horizontal Adduction	
		O'Brien's Test			Internal Rotation (90)			Internal Rotation (90)	
		Apley's Scratch Test			External Rotation (90)			External Rotation (90)	
		Adson's Test			Scapular Retraction			Shoulder Shrug	
		Allen's Test			Scapular Protraction				
		Piano Key (AC joint)							

COMMENTS:

ELBOWS / WRISTS / HANDS									
R	L	SPECIAL TESTS (+ or -)	R	L	ROM (WNL or L)	R	L	Strength Test (0 - 4)	
		Varus Stress Test			Elbow Flexion			Elbow Flexion	
		Valgus Stress Test			Elbow Extension			Elbow Extension	
		Milk Test			Supination			Supination	
		Tinel's Sign (Ulnar)			Pronation			Pronation	
		Tinel's Sign (Median)			Wrist Flexion			Wrist Flexion	
		MC/C Glide Test			Wrist Extension			Wrist Extension	
					Ulnar Radiation			Ulnar Radiation	
					Radial Radiation			Radial Radiation	
								Grip Strength	

COMMENTS:

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BACK / HIPS								
R	L	SPECIAL TESTS (+ or -)	R	L	ROM (WNL or L)	R	L	Strength Test (0 - 4)
		Step-off Deformity			Flexion			Flexion
		Stork Stance			Extension			Extension
					R Lateral Flexion			R Lateral Flexion
					L Lateral Flexion			L Lateral Flexion
					R Rotation			R Rotation
					L Rotation			L Rotation
					SI Joint Tracking			

COMMENTS:

KNEES								
R	L	SPECIAL TESTS (+ or -)	R	L	ROM (WNL or L)	R	L	Strength Test (0 - 4)
		Lachman's			Knee Flexion			Knee Flexion
		Anterior Drawer			Knee Extension			Knee Extension
		Posterior Drawer						
		Valgus Stress Test (0-30)						
		Varus Stress Test (0-30)						
		McMurray's						
		Patellar Apprehension						
		Sweep Test						
		Duck Walk (3 Steps)						

COMMENTS:

ANKLES / FEET								
R	L	SPECIAL TESTS (+ or -)	R	L	ROM (WNL or L)	R	L	Strength Test (0 - 4)
		Anterior Drawer			Dorsiflexion			Dorsiflexion
		Inversion Talar Tilt			Plantarflexion			Plantarflexion
		Eversion Talar Tilt			Inversion			Inversion
		Kleiger's Test			Eversion			Eversion
		Tinel's Sign (Navicular)						
		Navicular Drop Test						
		MT Glides						
		Toe Walks (5 Steps)						
		Heel Walks (5 Steps)						

COMMENTS:

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COVERAGE AND LIMITATIONS OF MEDICAL CARE

Athletically related medical conditions covered:

The injury or other condition must result from participation in a NMSU Athletics Department sponsored activity (physical conditioning, practice, competition & related travel).
The injury or other condition must be reported to Athletic Training staff within 7 days of occurrence.
Medical procedures must begin within 90 days of date of injury.
If needed, a surgery must be performed within six months of the onset of the injury or condition.
Athletic injuries occurring from supervised on campus training sessions during non-academic year

Non-Athletic medical conditions covered:

Illness or other medical condition which may restrict/hinder participation in intercollegiate athletics **LIMITED** to care provided by NMSU Medical staff and/or NMSU Student Health Center (SHC) or if otherwise approved by NMSU Athletic Training Staff.

Medical conditions not covered:

Illness or other medical conditions not related to athletic participation requiring medical care beyond the scope of the Team Physician or SHC.
Medical care provided without approval of NMSU Athletic Training Staff.
Pre-existing medical conditions are not covered.
Sexually transmitted disease, pregnancy or pre-natal care is not covered.
Illness or other medical condition occurring outside of the academic year

Restriction/Termination of Medical Service

Termination of athletic medical services for injuries or medical conditions received while participating as a student-athlete at NMSU shall be agreed as follows:

All arrangements for the care of such conditions are to be made **before** the student-athlete exhausts eligibility or as soon as a student-athlete quits or is removed from the team. The University will not accept any responsibility after a student-athlete has terminated his or her student affiliation with the University. A student-athlete's health status shall be determined by a physical examination by the NMSU Team Physician or his designee after finishing athletic competition. Medical care for on-going medical conditions occurring during the playing season will terminate at the end of the school year unless by mutual agreement. NCAA rules do not allow for the Athletics Department to provide or pay for medical care for conditions occurring after eligibility has been exhausted.

If any injury or medical condition occurs as a result of activities outside of athletic participation and prevents a student-athlete from further participation as a NMSU athlete, the NMSU Athletics Department has the right to discontinue financial aid awarded for athletic participation, or may require the student-athlete to perform Athletics Department services (student coach, manager, or office assistant) for continued financial aid.

By signing below, I agree that I have read this document and will abide by these policies

ATHLETE'S SIGNATURE _____ **DATE** _____

PRINT NAME _____ **SPORT** _____

If under 18 years of age, a parent/guardian signature is required:

PARENT'S SIGNATURE _____

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CONSENT FOR TREATMENT

I understand that I may be injured while participating in athletics at New Mexico State University. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become necessary while participating or traveling under NMSU supervision. I also authorize the University Athletic Training Staff to administer those treatments deemed necessary by the Team Physician.

ATHLETE'S SIGNATURE _____ **DATE** _____

If under 18 years of age, a parent/guardian signature is required for consent for treatment:

PARENT/GUARDIAN SIGNATURE _____

ACCEPTANCE OF RISK

I understand that participation in sports requires an acceptance of risk of injury. I understand that I may be permanently injured (paraplegia, quadriplegia, muscle or tendon injury) while playing sports and accept the risk. I understand I must follow the rules of my sport. I understand that I must refrain from practice or play while injured or ill, whether or not receiving medical treatment, and during medical treatment until I am discharged from treatment or given permission by the Team Physician to return to participation despite continuing treatment.

ATHLETE'S SIGNATURE _____ **DATE** _____

ACCEPTANCE OF REQUIREMENT OF INJURY NOTIFICATION

By signing below, I agree to immediately inform the New Mexico State University Sports Medicine staff of any or all injuries, illnesses, or medical conditions that occurs before or during my period of athletic participation at NMSU. These medical conditions may include, but are not limited to: cardiac conditions, respiratory disorders, concussions, heat illnesses, major joint injuries, major allergies, and significant medical disorders.

ATHLETE'S SIGNATURE _____ **DATE** _____

If under 18 years of age, a parent/guardian signature is required for consent for treatment:

PARENT/GUARDIAN SIGNATURE _____

CONSENT TO DRUG TESTING / CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby acknowledge that I have received a copy of the New Mexico State University Intercollegiate Athletics Department Drug Education, Testing, and Treatment Policy (the policy). I further acknowledge that I have read the Policy and that I fully understand the provisions of the Policy.

I hereby consent to have a sample of my urine or saliva collected and tested for the presence of banned drugs or substances in accordance with the provisions of the Policy, and at such other times as required under the Policy during the year _____.

I further authorize the program administrators to make a confidential release to my parent/legal guardian/spouse, the head coach of any intercollegiate athletic team in which I am a member, the athletics director, the team physician, certified athletic trainer, University administration, and designated attorneys of New Mexico State University, and any drug or substance abuse program which I may enter, of all information and records including test results relating to the screening or testing of my urine or saliva sample(s) in accordance with the provisions of the Policy which is applicable to all Intercollegiate Student-Athletes at New Mexico State University. To the extent set fourth in this document, I waive any privilege I may have in connection with such information. Further, this consent is given pursuant to all state and federal laws governing privacy, public records, and education records, and is a waiver of my right to non-disclosure authorized in the program.

I agree to participate in the Program and to be subject to its terms. I agree to cooperate in furnishing my urine or saliva specimens as required.

ATHLETE'S SIGNATURE _____ **DATE** _____

PRINT NAME _____ **SPORT** _____

If under 18 years of age, a parent/guardian signature is required for consent for the release of medical information:

PARENT/GUARDIAN SIGNATURE _____