



Region 9
School Based Health Center
Parent Consent for Treatment
575-630-7974



Student Name:		DOB:	
Insurance information	Does the student have Medicaid*?	YES	NO
	If yes, Medicaid ID:		
	If yes, Medicaid Provider:		
Primary Care Provider	Name:	Phone:	
I give permission for my child, named above, to receive SBHC services and for SBHC staff to access my child's class schedule (for appointment purposes only). Services include, but are not limited to, a comprehensive risk screening, mental health counseling, and physical health care. I give permission for my student to be seen via telemedicine when necessary and appropriate. I also give permission for the SBHC staff to consult with and provide information and records to other health care and mental health providers, including school health professionals, and for purposes of program evaluation and quality assurance. I understand that health records are confidential and will not be open to the school personnel unless the parent/guardian gives written consent, or in the case of treatment for which the minor has the right to consent, unless the minor gives written consent. I understand that New Mexico law does not require parental consent for treatment or advice about sexually transmitted diseases, pregnancy or contraception to minors under 18 years of age and behavioral health counseling services to minors age 14 years or older. I acknowledge that I have received a copy of the Notice of Privacy Practices.**			
Parent/Guardian Name:			
Parent/Guardian Signature:		Date:	

** Notice of Privacy Practices can be found at www.r9sbhc.org



NMAA PRE-PARTICIPATION EVALUATION (PPE) PACKET

*In accordance with New Mexico Activities Association Bylaw 6.15,
the following sports physical packet must be used for all pre-participation examinations.*

PURPOSE

The PPE is designed to **screen for injuries, illnesses, or other factors that increase an athlete's risk for injury or illness.** Experts in the field of athletic training, sports medicine, orthopaedics, family medicine, pediatrics, and osteopathics agree that the identification of predisposing factors that threaten one's safety are vital to participation in sport and will serve to improve the health and safety of athletes and active individuals.

The NMAA employs the use of the Preparticipation Physical Evaluation (PPE) Monograph, 5th Edition. The PPE Monograph was developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine. It is also endorsed by the National Athletic Trainers' Association and the National Federation of State High School Associations. The NMAA Sports Medicine Advisory Committee also endorses the use of the 5th PPE Monograph.

NMAA PPE REQUIRED FORMS

	Completed
✓ Emergency Information (parent/guardian)	☐
✓ *Medical History (parent/guardian)	☐
✓ *Physical Examination (HCP)	☐
✓ Medical Eligibility (HCP)	☐
✓ Consent to Treat (parent/guardian)	☐
✓ Concussion Awareness (parent/guardian/student)	☐

**Medical History and Physical Examination forms should remain with the parent/guardian and/or health care provider, unless parent/guardian provides written authorization to release the forms to the school.*

FOR PARENTS

- ✓ The **Medical History** form should be filled out jointly with your son or daughter prior to the appointment.
- ✓ Please pay special attention to the "**Heart Health Questions**" listed on the **Medical History** form.
- ✓ The **Medical History** and **Physical Examination** forms should remain with you and/or your health care provider unless written authorization is provided to release this information to the school.
- ✓ Return all other forms to the school. No forms need to be returned to the New Mexico Activities Association.

FOR SCHOOLS

- ✓ Schools should collect **Emergency Information, Medical Eligibility, Consent to Treat, and Concussion Awareness** forms.
- ✓ The **Medical History** and **Physical Examination** forms should NOT be collected unless written authorization is received from the parent/guardian.

NOTES FOR APPROVED HCP

- ✓ Healthcare providers should review **Medical History** prior to evaluation and **retain a copy in the medical file.**
- ✓ Healthcare providers should complete and sign the **Physical Examination** and **Medical Eligibility** forms.
- ✓ **Medical Eligibility** form should be returned to the parent/guardian to submit to the school.
- ✓ **Medical History** and **Physical Examination** forms should be returned to the parent/guardian to secure.
- ✓ **American Academy of Pediatrics Cardiac Screening Guidance:**
 - Primary care providers should be aware of features of the clinical history, family history and physical examination suggestive of a risk for SCA/SCD.
 - A thorough history, family history and physical examination are necessary to begin assessing for SCA/SCD risk.
 - The ECG should be the first test ordered when there is concern for SCA risk. It should be interpreted by a medical provider trained in recognizing electrical heart disease.
 - Survivors of SCA and family members of those with SCA or SCD should have a thorough evaluation to assess for a potential genetic etiology.



EMERGENCY INFORMATION

(Parent/Guardian, please fill out prior to examination)

STUDENT INFORMATION

NAME (Last, First, MI): _____ AGE: ____ GRADE: ____ DATE OF BIRTH: ____/____/____

EMAIL ADDRESS: _____ CELL PHONE: _____

HOME ADDRESS: _____
Street City State Zip

PARENT/GUARDIAN INFORMATION #1

NAME (Last, First): _____

PRIMARY PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

HOME ADDRESS: _____
Street City State Zip

PARENT/GUARDIAN INFORMATION #2 (if applicable)

NAME (Last, First): _____

PRIMARY PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

HOME ADDRESS: _____
Street City State Zip

EMERGENCY CONTACT

NAME (Last, First): _____

PRIMARY PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

HOME ADDRESS: _____
Street City State Zip

PARTICIPANT INSURANCE (Participants must be covered by accident/injury insurance prior to participation)

Insurance Carrier	Policy Number	Group ID
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SPORTS PARTICIPATING (Check all that apply)

Fall	Winter	Spring	Other
☐ Cross Country	☐ Basketball	☐ Baseball	☐ Bowling
☐ Football	☐ Cheer	☐ Golf	☐
☐ Soccer	☐ Dance	☐ Softball	☐
☐ Volleyball	☐ Powerlifting	☐ Tennis	☐
	☐ Swimming/Diving	☐ Track/Field	
	☐ Wrestling		

PARENT/GUARDIAN VERIFICATION (Print, Sign & Date)

Print Name _____ Sign Name _____

Date _____

A copy of this form should be placed into the athlete's medical file and should not be shared with schools or sports organizations without written authorization from parent/guardian.

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots
☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)		Yes	No
1. Do you have any concerns that you would like to discuss with your provider?			
2. Has a provider ever denied or restricted your participation in sports for any reason?			
3. Do you have any ongoing medical issues or recent illness?			
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?			
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			
7. Has a doctor ever told you that you have any heart problems?			
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.			

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No	
9. Do you get light-headed or feel shorter of breath than your friends during exercise?				
10. Have you ever had a seizure?				
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Unsure	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?				
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?				
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?				

This form should be returned to the parent to secure and should not be shared with schools or sports organizations without written authorization from parent/guardian.

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ (_____ / _____)	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: ☐ Y ☐ N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat - Pupils equal - Hearing		
Lymph nodes		
Heart ^a Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional Double-leg squat test, single-leg squat test, and box drop or step drop test		

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization. History and Physical Examination forms should not be shared with schools or sports organizations without written authorization from parent/guardian.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

☐ Medically eligible for certain sports

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____

NEW MEXICO ACTIVITIES ASSOCIATION

6600 PALOMAS AVE. NE
ALBUQUERQUE, NM 87109
PHONE: 505-923-3110
FAX: 505-923-3114

**CONSENT TO TREAT FORM**

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances, it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, as a member of the New Mexico Activities Association (NMAA), _____ (name of school or district) requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/NMAA, to the extent the QMP deems necessary to prevent harm to the student/athlete. It is understood that a QMP may be an athletic trainer, medical/osteopathic physician, physician assistant or nurse practitioner licensed by the state of New Mexico (or the state in which the student/athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by New Mexico law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designated by state regulation and standing protocols, and not for the purpose of making decisions about return to play.

PLEASE PRINT LEGIBLY OR TYPE

"I, _____ the undersigned, am the parent/legal guardian of, _____, a minor and student-athlete at _____ (name of school or district) who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/NMAA may employ or designate QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the designated state license, except as otherwise limited by New Mexico law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/NMAA."

Date: _____ Signature: _____



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

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 SB38

1. Remove immediately from activity when signs/symptoms are present.
2. Must not return to full activity prior to a minimum of 240 hours (10 days).
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.

Students need cognitive rest from the classroom, texting, cell phones, etc.

REFERENCES ON SENATE BILL 38 AND BRAIN INJURIES

Senate Bill 38:

<https://www.nmlegis.gov/Sessions/17%20Regular/final/SB0038.pdf>

For more information on brain injuries check the following websites:

<https://nfhslearn.com/courses/61059/concussion-for-students>

<http://www.nfhs.org/resources/sports-medicine>

<http://www.cdc.gov/concussion/HeadsUp/youth.html>

<http://www.stopsportsinjuries.org/concussion.aspx>

<http://www.ncaa.org/health-and-safety/medical-conditions/concussions>



SIGNATURES

By signing below, parent/guardian and athlete acknowledge the following:

- ♦ Both have received and reviewed the attached NMAA's *Concussion in Sports Fact Sheet for Athletes and Parents*.
- ♦ Both understand the risks of brain injuries associated with participation in school athletic activity, and are aware of the State of the New Mexico's Senate Bill 38; Concussion Law.
- ♦ Athlete has received brain injury training pursuant to Senate Bill 38.

Athlete's Signature

Print Name

Date

Parent/Guardian's Signature

Print Name

Date