



LAS VEGAS CITY SCHOOLS  
 ATHLETIC DEPARTMENT  
 901 Douglas Ave.  
 Las Vegas, NM 87701  
 (505) 454-5700  
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Juan Carlos Fulgenzi – Director of Co-Curricular Activities

**Appendix E**  
**LAS VEGAS CITY SCHOOL**  
**Interscholastic Athletic Medical Examination Form, Part I**

**Medical History (Parent/Guardian must complete before examination)**

Student-Athlete Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
 Home Address: \_\_\_\_\_ Age: \_\_\_\_\_ S.S. #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Parent Name: \_\_\_\_\_  
 Phone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_

**NOTE TO PARENTS**

In order that the best plans may be made for your child, it is necessary that we have your cooperation in filling out this questionnaire accurately before he/she can participate in interscholastic competition. After conferring with your child, please initial after each sport that you permit him/her to participate.

\_\_\_\_ Football    \_\_\_\_ Volleyball    \_\_\_\_ Boy's Basketball    \_\_\_\_ Girl's Basketball    \_\_\_\_ Cheer  
 \_\_\_\_ Boy's Track    \_\_\_\_ Girl's Track    \_\_\_\_ Baseball    \_\_\_\_ Softball  
 \_\_\_\_ Other: \_\_\_\_\_

	YES	NO
Do you want to talk to a doctor about a health problem .....	_____	_____
Has anyone in your family ever had:		
Diabetes .....	_____	_____
Allergies (Hay fever or asthma).....	_____	_____
Migraine Headaches .....	_____	_____
Heart Trouble .....	_____	_____
High Blood Pressure .....	_____	_____
Has anyone in your family, under age 50, died suddenly .....	_____	_____
Have you had or do you now have:		
Brain Concussion .....	_____	_____
Tendency to lose consciousness .....	_____	_____
Skull Fracture .....	_____	_____
Convulsion or Epilepsy .....	_____	_____
Neck Injury .....	_____	_____
Have you had or do you now have:		
Very bad vision in one eye .....	_____	_____
Temporary loss of vision .....	_____	_____
To wear glasses or contact lenses.....	_____	_____
Have you had or do you now have:		
Hearing Loss .....	_____	_____
Perforated Ear Drum .....	_____	_____
Recurrent Infections .....	_____	_____
Sinus Infections .....	_____	_____
Broken Nose .....	_____	_____
Dental Plate .....	_____	_____
Orthodontist .....	_____	_____
Have you had or do you now have:		
Hernia .....	_____	_____
Kidney Problems .....	_____	_____
(Boy's) Loss of function or absence of testicle(s).....	_____	_____
(Girl's) Menstrual Problems .....	_____	_____
Have you had or do you now have:		
Bone Fracture .....	_____	_____
Joint Dislocation .....	_____	_____
Foot Problems .....	_____	_____
Pins, staples and/or wires in any part of the body.....	_____	_____



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Have you had or do you now have:

- Back injury or frequent headaches..... \_\_\_\_\_
- Knee injury (sprain) or recurrent pain ..... \_\_\_\_\_
- Ankle injury (sprain) or recurrent pain ..... \_\_\_\_\_
- Other joint trouble ..... \_\_\_\_\_
- Bone infection..... \_\_\_\_\_

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**Interscholastic Athletic Medical Examination Form, Part I (con't.)**

YES    NO

Have you had or do you now have:

- Diabetes (high sugar in blood or urine)..... \_\_\_\_\_
- Tendency to bleed or bruise easily ..... \_\_\_\_\_
- Anemia (tired blood)..... \_\_\_\_\_
- Weight Problem (underweight or overweight) ..... \_\_\_\_\_

Have you had or do you now have:

- Asthma ..... \_\_\_\_\_
- Hay Fever ..... \_\_\_\_\_
- Hives or rash ..... \_\_\_\_\_
- Bee sting reactions (allergy)..... \_\_\_\_\_
- Reaction to medication..... \_\_\_\_\_
- If yes, please specify: \_\_\_\_\_

Do you:

- Smoke ..... \_\_\_\_\_
- Take any medication regularly ..... \_\_\_\_\_
- If yes, please specify \_\_\_\_\_

Have you had or do you now have:

- Heart trouble or murmur ..... \_\_\_\_\_
- Persistent cough ..... \_\_\_\_\_
- Chest pain with exercise ..... \_\_\_\_\_
- Dizziness or faintness with exercise ..... \_\_\_\_\_

Have you had or do you now have:

- Recurrent rash..... \_\_\_\_\_
- Fungus infection ..... \_\_\_\_\_
- Chronic athlete's foot ..... \_\_\_\_\_
- Recurrent boils (skin infection) ..... \_\_\_\_\_

Do you wish to discuss an emotional problem with the doctor?..... \_\_\_\_\_

Have you ever been told to give up sports because of a health problem? ..... \_\_\_\_\_

**Past history of injuries, operations, illnesses, etc. (include dates and doctors who handled case).**

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### Acknowledgement of Injury Risks

We, parent(s)/guardian(s) and student-athletes, are aware that preparation for and participation in interscholastic athletics involve 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, which may involve vigorous physical contact.

We parent(s)/guardian(s) and student-athlete have completely read, fully understand and voluntarily accept and agree to all of the above terms and conditions.

_____	_____	_____
Home Phone	Business Phone	Parent/Guardian Signature
_____	_____	_____
Date	Business Phone	Parent/Guardian Signature
		_____
		Student-Athlete Signature



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**Interscholastic Athletic Medical Examination Form, Part II**

**PHYSICIAN ONLY**

Student-Athlete Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height: \_\_\_\_' \_\_\_\_" Weight: \_\_\_\_\_ Blood Pressure \_\_\_\_/\_\_\_\_ Pulse: \_\_\_\_\_

Eyes:  
 Uncorrected R – 20/\_\_\_\_ L – 20/\_\_\_\_ Corrected R – 20/\_\_\_\_ L – 20/\_\_\_\_

	Normal	Abnormal	Remarks
<b>EENT</b>			
<b>Cardiovascular</b>			
<b>Abdomen</b>			
<b>Hernia</b>			
<b>Genitalia</b>			
<b>Musculoskeletal</b>			
<b>Neurological</b>			
<b>Deformities</b>			
<b>Surgical Scars</b>			
<b>Skin</b>			
<b>Urinalysis (Sugar)</b>			

I CERTIFY THAT I HAVE ON THIS DATE, REVIEWED THIS INDIVIDUALS MEDICAL HISTORY, EXAMINED THIS INDIVIDUAL AND FIND HIM/HER PHYSICALLY ABLE TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS.

Attending Physician (Printed Name): \_\_\_\_\_

Attending Physician (Signature): \_\_\_\_\_

Physicians Address: \_\_\_\_\_

Physicians Phone Number: \_\_\_\_\_

COMMENTS:

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