Kirtland Central High School
Home of the Broncos

Athletic Application

________________________________________________________

Student Athlete Name (Print)

Freshman  Sophomore  Junior  Senior
(Circle One)
ELIGIBILITY REQUIREMENTS

1. Pass a physical exam by a licensed physician.
2. Maintain a 2.0 GPA with no more than one F, as determined by the 9 weeks grade or the semester grade, which ever is higher.
3. You must be in school the day of a game or the day before a weekend game.
4. When entering a sport, you have five days to determine whether or not to stay with that sport. After the five days, you are locked into that sport for the duration of the season. Only the Head Coach may release the you after that.
5. The use of drugs or alcohol, tobacco, inhalants or any other mind altering substance will not be tolerated. Violation will result in an immediate 60 school day suspension during which you will be required to complete a school approved counseling program prior to participation in other extra-curricular activities at KCHS.
6. Unacceptable conduct at school, during athletic events, in the community and surrounding areas will result in discipline. You are representing your school, your community and your family. Be proud to be a BRONCO.
7. Unacceptable conduct by your parents/guardians, family members or specific interested parties before, during, and after a game may result in removal, restriction, and/or trespass from subsequent activities on KCHS campus per KCHS and NMAA.
8. Your playing time is solely determined by the coaching staff. If there are issues, you are required to follow protocol in seeking resolution.
9. Player ejection from a game, per NMAA, will be as follows:
   - 1st Offense- One game suspension and completion of NFHSLearn Sportsmanship course.
   - 2nd Offense/Subsequent Violations- Two game suspension, attend a meeting with the NMAA Executive Director/designee, additional sanctions as determined by KCHS and approved by the NMAA.

Please note that ejection suspension includes suspension from participation in practice, warm-ups or other direct involvement.
10. It is a PRIVILEGE not a RIGHT to participate in Kirtland Central High School athletics. With this privilege comes the responsibility to represent yourself, your parents/guardians, your school and your community with honor, respect and dignity.

AS AN ATHLETE AND PARENT/GUARDIAN, I HAVE READ THE ABOVE REQUIREMENTS AND AGREE TO ALLOW PARTICIPATION IN THE ATHLETIC PROGRAMS AT KIRTLAND CENTRAL HIGH SCHOOL.

___________________________________  __________________________________
Athlete (Print)  Athlete Signature/Date

___________________________________  __________________________________
Parent/Guardian (Print)  Parent/Guardian Signature/Date
ImPACT Testing: Baseline ImPACT Testing

1. Baseline ImPACT Testing will be scheduled at least one week after practice has started. Scheduled testing will take place prior to final roster posting.
2. Students not tested prior to the first scrimmage or game will be sidelined and listed as ineligible.

CCSD Concussion Protocol

1. The baseline ImPACT test is valid for two years.
2. The timeline for ImPACT test is unrelated to academic or athletic schedules.
3. The NMAA Concussion Consent Form will be signed by both the athlete and parent/guardian prior to administering the test.
4. School Officials (Athletic Director or Coaches) are responsible for securing computer labs for baseline ImPACT testing.
5. School Officials will schedule a mutually agreed time with Dr. Waters for baseline testing.
6. Coaches will assist in monitoring their athletes during the testing session.


Heads Up: Concussion

Student Athlete (Print Name): _____________________________ Grade: ________________

Student Athlete Signature: ________________________________ Date: __________________

Parent/Guardian (Print Name): ______________________________

Parent/Guardian Signature: ________________________________ Date: __________________
Please complete the following information:

<table>
<thead>
<tr>
<th>Student Athlete Name: (Last, first, MI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB: Age: Grade:</td>
</tr>
<tr>
<td>Mailing Address:</td>
</tr>
<tr>
<td>Physical Address:</td>
</tr>
<tr>
<td>Parent/Guardian:</td>
</tr>
</tbody>
</table>

SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN *(CHECK ALL THAT APPLY)*

- [ ] Baseball
- [ ] Basketball
- [ ] Cheer/Drill
- [ ] Cross Country
- [ ] Football
- [ ] Golf
- [ ] Soccer
- [ ] Softball
- [ ] Track
- [ ] Volleyball
- [ ] Wrestling
- [ ] Other __________

__________________________  _________________________
Athlete (Print)           Athlete Signature/Date

__________________________  _________________________
Parent/Guardian (Print)    Parent/Guardian Signature/Date

Please answer all health history questions on the following page PRIOR to your visit to the doctor. Please complete the student-athlete's personal information on each page and return the entire packet to the KCHS Athletic Department.
ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: Health History From

Student-Athlete Name: ___________________________ Gender: __________ DOB: __________

1. Has a doctor ever denied or restricted your participation in sports for any reason? __Yes __No
2. Do you have an ongoing medical condition (i.e. asthma, diabetes, high blood pressure)? __Yes __No
3. Are you currently taking any prescription or over the counter medication? __Yes __No
4. Do you have any allergies to medicines, pollen, foods or stinging insects? If yes, please circle
   __Yes __No
5. Have you ever become dizzy or passed out during or after exercise? __Yes __No
6. Have you had chest pain or shortness of breath during or after exercise? __Yes __No
7. Do you get more tired than your friends do during exercise? __Yes __No
8. Has a doctor ever told you that you have high blood pressure? __Yes __No
9. Has a doctor ever told you that you have a heart murmur or "heart trouble"? __Yes __No
10. Do you have difficulty breathing during or after exercise? __Yes __No
11. Has a doctor ever told you that you have asthma or allergies? __Yes __No
12. Do you have a cough that doesn't go away or wheeze or have difficulty breathing during or after exercise? __Yes __No
13. Have you ever used an inhaler or taken asthma medicine? __Yes __No
14. Has a doctor ever ordered a test for your heart (i.e. ECG, echocardiogram)? __Yes __No
15. Has anyone in your family ever died for no apparent reason? __Yes __No
16. Does anyone in your family have a heart problem? __Yes __No
17. Has a family member or relative died of heart problems or sudden death before the age of 50? __Yes __No
18. Have you ever felt like your heart was racing or skipped heartbeats? __Yes __No
19. Have you ever had an injury like a sprain, pulled muscle or torn ligament or tendonitis that has caused you to miss a game or practice? Please list: ____________________________ __Yes __No
20. Have you had a herpes infection? __Yes __No
21. Have you ever had bone or joint injury that required injection, x-rays, MRI, CT? (Please circle one or more) __Yes __No
22. Have you ever had Surgery? __Yes __No
23. Have you ever had to go to: Physical Therapy or Rehabilitation __Yes __No
24. Have you ever been fitted with a brace, splint, cast, crutches? Yes No (If yes, please circle one or more)
25. Have you ever had a stress fracture? Yes No. If yes please list location__________________________
26. Do you regularly wear a Ace wrap or brace or splint? __Yes __No
27. Were you born without or missing a kidney, an eye or testicle or any other organ? __Yes __No
28. Have you had a severe viral infection such as infectious mononucleosis (mono) or chronic fatigue? __Yes __No
29. Do you have any rashes, or acne or other skin problems? __Yes __No
30. Have you had a herpes infection? __Yes __No
31. Have you had a knocked out or passed out after being hit by an object? __Yes __No
32. Have you ever had a concussion or hit in the head or after being hit in head complained of:
   Headache, dizzy spells, feeling confused or difficulty concentrating or forgetful? (please circle one or more)
   Yes No
33. Have you ever been unable to move your arms or legs after being hit or fallen down? __Yes __No
34. Have you ever had a seizure or convulsions? __Yes __No
35. Do you have headaches? If yes, how often? __Yes __No
36. Have you ever had tingling or numbness or weakness in your arms, hands, legs or feet? __Yes __No
37. While exercising have you ever had severe muscle cramps or muscle tightness? __Yes __No
38. Have you ever suffered from heat illness or heat stroke or passed out while exercising in the heat? __Yes __No
39. Have you had any problems with your eyes or vision? __Yes __No
40. Do you wear glasses or contacts? __Yes __No
41. Do you wear protective eyewear such as goggles or a face shield? __Yes __No
42. Are you trying to gain or lose weight? __Yes __No
43. Has anyone recommended you change your weight or eating habits? __Yes __No
44. Have you ever missed a period? __Yes __No
45. How old were you when you had your first menstrual period or "monthly? _____________
46. Are your menstrual periods "regular" or every 30 days? __Yes __No
   More frequent? __Yes __No
   Less frequent? __Yes __No
47. Have you ever had a concussion or hit in the head or after being hit in head complained of:
   Dizziness, confusion, feeling down? __Yes __No
48. Has a family member or relative died of heart problems or sudden death before the age of 50? __Yes __No
49. Has a doctor ever denied or restricted your participation in sports for any reason? __Yes __No
50. Has a doctor ever told you that you have asthma or allergies? __Yes __No
51. Has a doctor ever told you that you have high blood pressure? __Yes __No
52. Has a doctor ever told you that you have a heart murmur or "heart trouble"? __Yes __No
53. Has a doctor ever ordered a test for your heart (i.e. ECG, echocardiogram)? __Yes __No
54. Has anyone recommended you change your weight or eating habits? __Yes __No
55. Have you ever missed a period? __Yes __No

**Please use the back of the form if necessary for explanations.
ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM
Part B: Physical Examination

**TO BE COMPLETED BY THE EXAMINING PHYSICIAN OR PROVIDER-PLEASE COMPLETE BOTH PAGES**

Student-Athlete Name: ___________________________ Gender: _______ DOB: ________

BMI %ile ______ Pulse ______ Blood Pressure ______/______ Blood Pressure %ile ______ Height ______ Weight ______

Vison: R20/____ L20/____ Corrected: Y / N Does Athlete wear contacts? Y / N Pupils: Equal _____ Unequal _____

Does Athlete require eye protection while playing? Y / N

### Medical

<table>
<thead>
<tr>
<th></th>
<th>Normal (Please Circle)</th>
<th>Abnormal Findings/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Eyes/Ears/Nose/Throat</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Hearing</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Heart (Ascultation should be done supine and standing-abnormal findings require referral of further evaluation)</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Murmurs</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Pulses</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Lungs: Auscultation</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Abdomen: Assessment (incl. liver, spleen)</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Skin</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

### Musculoskeletal

<table>
<thead>
<tr>
<th></th>
<th>Normal (Please Circle)</th>
<th>Abnormal Findings/Comments</th>
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<tbody>
<tr>
<td>Neck</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Back</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Shoulder/Arm</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Elbow/Forearm</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Wrist/Hand/Fingers</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Knee</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Leg/Ankle</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Foot/Toes</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

Notes:________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
Part B: Clearance Form

Athlete Name: ________________________________  Gender: __________  DOB: _________________

SAMPLES OF CLASSIFICATION OF SPORT BY CONTACT

<table>
<thead>
<tr>
<th>Contact/Collision</th>
<th>Limited Contact</th>
<th>Non-Contact/Strenuous</th>
<th>Non-Contact/Non Strenuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rodeo</td>
<td>Baseball</td>
<td>Discus</td>
<td>Bowling</td>
</tr>
<tr>
<td>Football</td>
<td>Cheerleading</td>
<td>Javelin</td>
<td>Golf</td>
</tr>
<tr>
<td>Soccer</td>
<td>High Jump</td>
<td>Shot Put</td>
<td></td>
</tr>
<tr>
<td>Wrestling</td>
<td>Softball</td>
<td>Running/Cross Country</td>
<td></td>
</tr>
<tr>
<td>Basketball</td>
<td>Volleyball</td>
<td>Strength Training</td>
<td>Track</td>
</tr>
</tbody>
</table>

Student-Athlete MAY participate in the following types of sports (Check all applicable):

☐ STUDENT CLEARED FOR ALL FORMS OF ATHLETICS
☐ Contact/Collision  ☐ Limited Contact  ☐ Non-Contact/Strenuous  ☐ Non-contact/Non-Strenuous

☐ Student Cleared for Participation

☐ Student Cleared for Participation PENDING:__________________________________________________

☐ Student NOT Cleared for Participation

**Student-Athlete Emergency Information**

Allergies:______________________________  History of Anaphlaxis? ☐ Yes  ☐ No

Immunizations Current? ☐ Yes ☐ No  Last Tetanus Immunization:________________

Significant Medical History Information/Current Medical Conditions *(Please include any history of asthma, hypertension, previous head injury, unequal pupil size, etc.)*

Primary Provider’s Name:____________________________________  Phone: __________________

Address: _____________________________________________________________________________

Provider’s Signature: ___________________________________________  Date: ___________________
Central Consolidated Schools
Emergency Profile

To Parents/Guardians and Student-Athlete:

Please read the following statements concerning the participation of your child in interscholastic athletics. Respond below with your signature.

I hereby give my consent for my child to participate in interscholastic athletics and authorize CCSD to provide the information on the form to the New Mexico Activities Association. The financial responsibility for securing care of athletic injuries is a matter between the parent/guardian and the physician/doctor of osteopathy/physician assistant or dentist of parent/guardian’s selection. CCSD may not pay doctors, dentists or hospitals for any treatment of any child.

Student-Athlete Name: ___________________________ Student ID Number: __________

Grade: ____________ Census #: _________________ IHS #: ________________

Parent/Guardian: ____________________________

Phone #: ______________(Home) ______________(Cell) ______________(Work)

Mailing Address: _______________________________________________________

Physical Address: _______________________________________________________

Emergency Contacts

Name: ________________________________ Relationship: ______________________

Phone #: _______________(Home) ______________(Cell) ________________(Work)

Name: ________________________________ Relationship: ______________________

Phone #: _______________(Home) ______________(Cell) ________________(Work)
Central Consolidated Schools
Emergency Profile
Insurance Information

We have applied for Student Accident Insurance. Please Circle YES NO

Insurance Company: _________________________________________________________

Group/Plan Number: _______________________ Policy Number: _______________________

Primary Provider’s Name:____________________________ Phone: _______________________

Address:______________________________________________________________________

Dentist:_________________________________________ Phone: _________________________

Address:______________________________________________________________________

Hospital Preference: _____________________________________________________________


AUTHORIZATION FOR MEDICAL SERVICES

I request that I be contacted within a reasonable time frame in the event of illness or injury requiring medical services. In the event I cannot be reached, I hereby designate the athletic director, team coach, athletic trainer or their designee to act on my behalf to authorize medical attention, hospitalization and surgery as may be required in an emergency because of illness or injuries sustained by my child while participating in school athletics. In the event that I cannot be reached and the situation calls for medical attention, I recognize and relinquish our responsibility to the practicing physician or other medical personnel to act in the best interest of my child. I hereby assume financial responsibility for medical attention, hospitalization and surgery.

___________________________________  _______________________________________
Parent/Guardian (Print)  Parent/Guardian Signature/Date