



LAS VEGAS CITY SCHOOLS
 ATHLETIC DEPARTMENT
 901 Douglas Ave.
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 (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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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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**Appendix E
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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
EENT			
Cardiovascular			
Abdomen			
Hernia			
Genitalia			
Musculoskeletal			
Neurological			
Deformities			
Surgical Scars			
Skin			
Urinalysis (Sugar)			

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:
