

**Nerf League of Las Cruces  
SAFETY AND WELFARE STATEMENT**

Team: \_\_\_\_\_ Division: \_\_\_\_\_  
Player's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
School Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Place Of Birth: \_\_\_\_\_  
Parent/Legal Guardian Name: \_\_\_\_\_ School Last Attended: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip : \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

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**Safety and Welfare Of The Student-Athlete**

The Nerf League of Las Cruces has a deep concern for the safety and welfare of its athletes. We feel the reading and understanding of this form is essential for providing assurances to the student-athletes, parents, and the Nerf League that each individual participant is physically capable of participating in the Nerf League of Las Cruces.

Therefore, it is of utmost importance that this form is read and completed by both the student-athlete and the parent or court appointed guardian and returned to your Head Coach.

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**Permission To Participate In The Nerf League of Las Cruces**

\_\_\_\_\_ has my permission to participate in the Nerf League of Las Cruces under the supervision and responsibility of USAFootball certified coaches.

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**Assumption Of Liability And Risk**

We have familiarized ourselves with the benefits and limitations of the Nerf League of Las Cruces medical insurance program and our individual family's medical insurance program and will not hold the Nerf League of Las Cruces, it's members, staff or volunteers responsible for liability if an accident or injury should occur. We assume all risks and hazards incidental to the conduct of the activities, and transportation to and from such activities. We do hereby release, absolve, indemnify, and hold harmless the Nerf League of Las Cruces, the event organizers, supervisory personnel, sponsors, coaches, athletic trainers, and supervisors, and or all of them, individually or as a group. In case of an injury to our son or daughter, we hereby waiver all claims against the event organizers, sponsors, coaches, athletic trainers, and supervisors, and or all of them the Nerf League of Las Cruces, the event organizers and supervisory personnel, sponsors, coaches, athletic trainers, and supervisors, individually or as a group.

We, the student-athlete and parent or court appointed guardian, acknowledge that we have completely read, fully understand, and voluntarily assent and agree to the above terms, conditions, and statements.

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**Acknowledgement Of Injury Risks**

We, the student-athlete and parent or court appointed guardian, are aware that participation in the Nerf League of Las Cruces involves risks of serious and permanent injury to the athlete. We understand and acknowledge the danger and risk of these severe injuries as inherent to participation in the Nerf League of Las Cruces.

We, the student-athlete and parent or court appointed guardian, acknowledge that we have completely read, fully understand, and voluntarily assent and agree to the above terms, conditions, and statements.

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**Personal Medication Notification**

For protection of the student-athlete, we the student-athlete and parent or court appointed guardian, will inform the athletic trainer, coaches, and/or medical doctors if the student-athlete is taking any medication or using ointment, liniment, balm, or has a metal implant in his/her body BEFORE receiving therapy or treatment of any kind from the athletic trainer or medical doctor.

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**Insurance**

**Please Check One:**

Name of Insurance Company \_\_\_\_\_ Policy Number: \_\_\_\_\_  
(Please attach a copy of your insurance card)

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**Concussions:**

A concussion is a disturbance in the function of the brain caused by a blow to the body or head, occurring in any sport or activity. It results in a variety of symptoms (headache, nausea, dizziness, memory or balance problems) with or without loss of consciousness. I (we) understand that there is a concussion protocol established by the league that includes care and return to play and will report and follow the guidelines set for return to play if such an injury occurs.

We the student-athlete and parent or court appointed guardian acknowledge and agree that we have read, understand, and will abide by the above stated conditions.

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\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Court Appointed Legal Guardian Signature

\_\_\_\_\_  
Date

**Medical History – Parent/Guardian please fill out prior to examination**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_  
 (Please Print) Last First MI  
 Place of Birth: \_\_\_\_\_ Last School Attended: \_\_\_\_\_  
 City State School City State  
 Mailing Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Street City State Zip  
 Name of Parent/Guardian: \_\_\_\_\_ Work / Cell Phone: \_\_\_\_\_

**Explain "Yes" answers below**

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	1	1
2. Do you have an ongoing medical condition (like asthma or diabetes)?	1	1
3. Are you currently taking any prescription or nonprescription medications or pills?	1	1
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	1	1
5. Have you ever become dizzy or passed out <b>During or After</b> exercise?	1	1
6. Have you ever had chest discomfort, pain or pressure during or after exercise?	1	1
7. Do you get more tired than your friends during exercise?	1	1
8. Has a doctor ever told you that you have: (check all that apply)	1	1
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur		
<input type="checkbox"/> Heart infection <input type="checkbox"/> High cholesterol		
9. Has a doctor ever ordered a test for your heart? (ECG, echocardiogram)	1	1
10. Has anyone in your family ever died for no apparent reason?	1	1
11. Does anyone in your family have a heart condition starting under the age of 50?	1	1
12. Has a family member or relative died of heart problems or sudden death before the age of 50?	1	1
13. Have any of relatives ever had one of the following conditions? Hypertrophic cardiomyopathy, Marfan's syndrome, Long QT syndrome or a significant heart arrhythmia	1	1
14. Have you ever had racing of your heart or skipped heart beats?	1	1
15. Have you ever spent the night in a hospital?	1	1
16. Have you ever had surgery?	1	1
17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? (if Yes, circle below)	1	1
18. Have you had any broken or fractured bones or dislocated joints? (if yes, circle below)	1	1
19. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections rehabilitation, physical therapy, a brace, a cast or crutches?	1	1
Head Neck Shoulder Upper arm Elbow		
Calf Hand Chest Upper back Lower back		
Forearm Thigh Knee Ankle Foot Toe		
20. Have you ever had a stress fracture?	1	1

	Yes	No
21. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?	1	1
22. Do you regularly use a brace or assistive device?	1	1
23. Has a doctor ever told you that you have asthma or allergies?	1	1
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	1	1
25. Is there anyone in your family with asthma?	1	1
26. Have you ever used an inhaler or taken asthma medicine?	1	1
27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ?	1	1
28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?	1	1
29. Do you have any rashes, pressure sores or other skin problems?	1	1
30. Have you had a herpes infection?	1	1
31. Have you had a head injury or concussion?	1	1
32. Have you been hit in the head and been confused or lost your memory?	1	1
33. Have you ever had seizure?	1	1
34. Do you have headaches with exercise?	1	1
35. Have you ever had numbness or tingling or weakness in your arms or legs?	1	1
36. Have you ever been unable to move your arms or legs after being hit or fallen?	1	1
37. When exercising in the heat, do you have severe muscle cramps or become ill?	1	1
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	1	1
39. Have you had any problems with your eyes or vision?	1	1
40. Do you wear glasses or contacts?	1	1
41. Do you wear protective eyewear such as goggles or a face shield?	1	1
42. Are you unhappy with your weight?	1	1
43. Are you trying to gain or lose weight?	1	1
44. Has anyone recommended you change your weight or eating habits?	1	1
45. Do you limit or carefully control what you eat?	1	1
46. Do you have concerns that you would like to discuss with the doctor / health care provider?	1	1
<b>FEMALES ONLY:</b>		
47. Have you ever had a menstrual period?	1	1
48. How old were you when you had your first menstrual period? _____		
49. How many periods have you had in the last 12 months? _____		

**Explain "Yes" answers here:**

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS VALID AND CORRECT:**

Student-Athlete Signature \_\_\_\_\_ Parent or Court Appointed Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**I VERIFY THAT I HAVE REVIEWED THE ABOVE INFORMATION**

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM** **PHYSICAL EXAMINATION**

Athlete Name \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_/\_\_\_\_\_, (\_\_\_\_\_/\_\_\_\_\_, \_\_\_\_/\_\_\_\_)  
 Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y \_\_\_\_\_ N \_\_\_\_\_ Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

<b>MEDICAL</b>	<b>Normal</b>	<b>Abnormal</b>
<b>Findings/Comments</b>		

Appearance
(any physical finding of Marfan's syndrome)
Eyes/Ears/Nose/Throat ( <i>if indicated</i> )
Hearing ( <i>if indicated</i> )

**Heart (*auscultation should be done supine and standing- abnormal findings require referral for further evaluation*)**

Murmurs
Pulses
Lungs: Auscultation
Abdomen:
Genitourinary ( <i>only if indicated</i> )
Skin

**MUSCULOSKELETAL**

Neck
Back
Shoulder/Arm
Elbow/Forearm
Wrist/Hand/Fingers
Hip/Thigh
Knee
Leg/Ankle
Foot/Toes

NOTES: \_\_\_\_\_  
 \_\_\_\_\_

Student MAY participate in the following types of sports (CHECK ALL THAT APPLY):

- ALL FORMS OF SPORTS**
- CONTACT/COLLISION
- NON-CONTACT/STRENUOUS
- LIMITED CONTACT NON-CONTACT/NON-STRENUOUS
- STUDENT CLEARED FOR PARTICIPATION PENDING (explanation) \_\_\_\_\_
- STUDENT NOT CLEARED FOR PARTICIPATION (explanation) \_\_\_\_\_

Name of Physician/Provider (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Physician /Provider \_\_\_\_\_

Student's Primary Physician/Provider (for follow up, if necessary): \_\_\_\_\_

# Sport Concussion Information Paper

A concussion is a disturbance in the function of the brain caused by a blow to the body or head, occurring in any sport or activity

Signs to watch for:

- Headache
- Nausea
- Dizziness
- Problems with Memory
- Balance problems

Problems could arise over the first 24-48 hours. You should not be left alone and must go to a hospital at once if you:

- Have a headache that gets worse
- Are very drowsy or can't be awakened (woken up)
- Can't recognize people or places
- Have repeated vomiting
- Behave unusually or seem confused, are very irritable
- Have seizures (arms and legs jerk uncontrollably)
- Are unsteady on your feet; have slurred speech

Remember: it is better to be safe: **Consult your doctor after a suspected concussion.**

Remember, concussion should be suspected in the presence of ANY ONE or more of the following:

- Symptoms (such as a head ache), or
- Signs (such as loss of consciousness), or
- Memory problems

Any athlete with a suspected concussion should be monitored for deterioration (i.e., should not be left alone) and should not drive a motor vehicle.

Return to play:

Athletes should not be returned to play the same day of injury.

When returning athletes to play, they should follow a stepwise symptom-limited program, with stages of progression. For example:

1. Rest until asymptomatic (physical and mental rest)
2. Light aerobic exercise (e.g. stationary bike)
3. Sport-specific exercise (running, jogging, lateral movement)
4. Non-contact training drills (start light resistance training)
5. Full contact training after medical clearance
6. Return to competition (game play)

There should be approximately 24 hours (or longer) for each stage and the athlete should return to stage 1 if symptoms recur. Resistance training should only be added in the later stages. Medical clearance should be given before return to play, and the athlete must have NO symptoms

We the student-athlete and parent or court appointed guardian acknowledge and agree that we have read, understand, and will abide by the above stated conditions.

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\_\_\_\_\_  
Student-Athlete Signature  
\_\_\_\_\_  
Parent or Court Appointed Legal Guardian Signature

\_\_\_\_\_  
Date  
\_\_\_\_\_  
Date