1a

PHYSICAL EXAMINATION AND PARENT PERMIT FOR ATHLETIC PARTICIPATION - PART I

I hereby certify that I have examined _____ and that the student was found physically fit to engage in high school sports (except as listed on back).

Student's birth date _____ Exp. Date (good for 365 days) _____

PARENT OR GUARDIAN PERMIT

WARNING: Although participation in supervised interscholastic athletics and activities may be one of the least hazardous in which any student will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC INJURY.** Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate this risk.

PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR OWN EQUIPMENT DAILY.

By signing this Permission Form, we acknowledge that we have read and understood this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM. By signing this form it allows my students medical information to be shared with appropriate medical staff when necessary in compliance with HIPPA (Health Insurance Portability and Accountability Act) Regulations.**

I hereby give my consent for _____ to compete in athletics for High School in Colorado High School Activities Association approved sports, except as listed on back, and I have read and understand the general guidelines for eligibility as outlined in the Competitor's Brochure.

Parent or Guardian Signature _____ Date _____

I have read, understand and agree to the General Eligibility Guidelines as outlined in the Competitor's Brochure.

Student Signature _____ Date _____

Insurance

A student must have insurance coverage to participate in athletics. I wish my child insured under the student insurance available through the Wiggins School District RE-50J (Insurance applications are available from the front office).

Yes____ No____

I will not need the student insurance available through the school since my child is insured by;

Insurance Company _____ Policy # _____

Emergency Contacts

Family Physician _____ Telephone # _____

If the parent or guardian cannot be reached, list the name and telephone number of someone who can be contacted in case of an accident or serious illness (***telephone number must be different from that of the parent or guardian***).

Name _____ Telephone # _____

PART II – MEDICAL HISTORY

This form must be completed and signed, prior to the physical examination, for review by examining physician. Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.

	MEDICAL HISTORY OF STUDENT & FAMILY	YES	NO
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3.	Are you currently taking any prescription or non-prescription (over the counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods or stinging insects?	☐	☐
5.	Do you have prescriptions for use of epinephrine, adrenalin, inhaler, or other allergy medications?	☐	☐
6.	Have you ever passed out or nearly passed out during or after exercise?	☐	☐
7.	Have you ever passed out or nearly passed out at any other time?	☐	☐
8.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9.	Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath?	☐	☐
10.	Does your heart race or skip beats during exercise?	☐	☐
11.	Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
12.	Has a doctor ever ordered a test for your heart?	☐	☐
13.	Has anyone in your family died suddenly for no apparent reason?	☐	☐
14.	Does anyone in your family have a heart problem?	☐	☐
15.	Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death.)	☐	☐
16.	Does anyone in your family have Marfan syndrome?	☐	☐
17.	Have you ever spent the night in a hospital?	☐	☐
18.	Have you ever had surgery?	☐	☐
19.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	☐	☐
20.	Have you had any broken or fractured bones or dislocated joints?	☐	☐
21.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	☐	☐
22.	Have you ever had a stress fracture?	☐	☐
23.	Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?	☐	☐
24.	Do you regularly use a brace or assistive device?	☐	☐
25.	Have you ever been diagnosed with asthma or other allergic disorders?	☐	☐
26.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
27.	Is there anyone in your family who has asthma?	☐	☐
28.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
29.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
30.	Have you had infectious mononucleosis (mono) within the last three months?	☐	☐
31.	Have you ever had mono or any illness lasting more than two weeks?	☐	☐

	MEDICAL HISTORY OF STUDENT & FAMILY	YES	NO
32.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
33.	Have you ever had herpes skin infection?	☐	☐
34.	Have you ever had a head injury or concussion?	☐	☐
35.	Date of last head injury or concussion:		
36.	Have you ever been hit in the head and been confused or lost your memory?	☐	☐
37.	Have you ever been knocked unconscious?	☐	☐
38.	Have you ever had a seizure?	☐	☐
39.	Do you have headaches with exercise?	☐	☐
40.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
41.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
42.	When exercising in heat, do you have severe muscle cramps or become ill?	☐	☐
43.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
44.	Have you had any other blood disorders or anemia?	☐	☐
45.	Have you had any problems with your eyes or vision?	☐	☐
46.	Do you wear glasses or contact lenses?	☐	☐
47.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
48.	Are you happy with your weight?	☐	☐
49.	Are you trying to gain or lose weight?	☐	☐
50.	Do you limit or carefully control what you eat?	☐	☐
51.	Has anyone recommended you change your weight or eating habits?	☐	☐
52.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
53.	What is the date of your last Tetanus immunization? Date: _____		
	FEMALES ONLY		
54.	Have you ever had a menstrual period?	☐	☐
55.	Age when you had your first menstrual period?		
56.	How many periods have you had in the last 12 months?		
57.	Do you take a calcium supplement?	☐	☐
	Explain "Yes" answers here:		

Parent/Guardian Signature: _____

Athlete's Signature: _____

PART III -- PHYSICAL EXAMINATION

NAME: _____ SCHOOL: _____

HEIGHT: _____ WEIGHT: _____ SEX: _____ AGE: _____ DOB: _____

*Tanner Stage or Maturation Index? (males only): _____ BP: _____

*Percent Body Fat: _____ Pulse: *(rest) _____

*Audiogram _____ *(Exercise) _____

*(Recovery) _____

*FEV or Peak Flow (rest) _____

* Vision: Corrected: (L) _____ (R) _____ (Both) _____ *(Exercise) _____

Uncorrected (L) _____ (R) _____ (Both) _____ *(Recovery) _____

	N	Abnormal		N	Abnormal
Eyes			Cervical Spine/neck		
Ears			Back		
Nose			Shoulders		
Throat			Arm/elbow/wrist/hand		
Teeth			Knees/hips		
Skin			Ankle/feet		
Lymphatic			Marfan Screen		
Lungs			*Urine		
Heart			*Hemoglobin or HCT and or Iron stores		
Peripheral pulses			^Echocardiogram		
Abdomen			^Neuropsyc Testing		
Genitalia/hernia (male only)			^Pelvic Examination		

***WHEN MEDICALLY INDICATED**
(Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)

^WITH SPECIAL INDICATIONS
(These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decision.)

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

- ☐ **CLEARED WITHOUT RESTRICTIONS**
- ☐ **Cleared AFTER further evaluation or treatment for:** _____
- ☐ Cleared for **Limited participation** (check and explain "reason" for all that apply):
  - ☐ Not cleared for (specific sports): _____
  - ☐ Cleared only for (specific sports): _____
    Reason(s): _____
- ☐ **NOT CLEARED FOR PARTICIPATION:** _____
  Reason(s): _____
- ☐ Other Recommendations: _____
  - ☐ Recommend monitoring during early conditioning because of weight/fitness/other
  - ☐ Recommend restrictions or monitoring of weight loss or gain
  - ☐ Other: Reasons: _____

MD/DO, PA, NP, DE-SPC#, Signature: _____

Date of Examination: _____ Date Signed: _____

NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR and degree: (print):

_____

Address: _____

City _____ State _____ Zip _____