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 _____

No student shall represent their school in interschool athletics until there is on file with the superintendent or principal a statement signed by his parent or legal guardian and a signed physical certifying that he/she has passed an adequate physical examination within the past year, that in the opinion of the examining physician, physician's assistant, nurse practitioner or a certified/registered chiropractor, he/she is physically fit to participate in high school athletics; and that he/she has the consent of his/her parents or legal guardian to participate.

NOTE: It is strongly recommended by the Colorado Department of Health that individuals participating in athletic events have current tetanus boosters. Tetanus boosters are recommended every 10 years throughout life. Boosters are recommended at the time of injury if more than five years have elapsed since the last booster.

If significant intervening illnesses and/or injuries have occurred, a more complete physical examination should be conducted. The physical examination form must be signed by a practicing physician, physician assistant, or nurse practitioner.

If a student athlete has been injured in practice and/or competition, the nature of which required medical attention, the student athlete should not be permitted to return to practice and/or competition until he/she has received a release from a practicing physician.

NOTE: The CHSAA urges an adequate physical examination be given when a student athlete changes levels of competition, i.e. Little League to Middle School, Middle School to High School.

PHYSICIAN SIGNATURE REQUIRED ON BACK

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		MEDICAL HISTORY OF STUDENT & FAMILY	YES	NO
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐	32.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐	33.	Have you ever had herpes skin infection?	☐	☐
3.	Are you currently taking any prescription or non-prescription (over the counter) medicines or pills?	☐	☐	34.	Have you ever had a head injury or concussion?	☐	☐
4.	Do you have allergies to medicines, pollens, foods or stinging insects?	☐	☐	35.	Date of last head injury or concussion: _____		
5.	Do you have prescriptions for use of epinephrine, adrenalin, inhaler, or other allergy medications?	☐	☐	36.	Have you ever been hit in the head and been confused or lost your memory?	☐	☐
6.	Have you ever passed out or nearly passed out during or after exercise?	☐	☐	37.	Have you ever been knocked unconscious?	☐	☐
7.	Have you ever passed out or nearly passed out at any other time?	☐	☐	38.	Have you ever had a seizure?	☐	☐
8.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	39.	Do you have headaches with exercise?	☐	☐
9.	Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath?	☐	☐	40.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
10.	Does your heart race or skip beats during exercise?	☐	☐	41.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
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			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?	☐	☐
12.	Has a doctor ever ordered a test for your heart?	☐	☐	44.	Have you had any other blood disorders or amenia?	☐	☐
13.	Has anyone in your family died suddenly for no apparent reason?	☐	☐	45.	Have you had any problems with your eyes or vision?	☐	☐
14.	Does anyone in your family have a heart problem?	☐	☐	46.	Do you wear glasses or contact lenses?	☐	☐
15.	Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death.)	☐	☐	47.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
16.	Does anyone in your family have Marfan syndrome?	☐	☐	48.	Are you happy with your weight?	☐	☐
17.	Have you ever spent the night in a hospital?	☐	☐	49.	Are you trying to gain or lose weight?	☐	☐
18.	Have you ever had surgery?	☐	☐	50.	Do you limit or carefully control what you eat?	☐	☐
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?	☐	☐	51.	Has anyone recommended you change your weight or eating habits?	☐	☐
20.	Have you had any broken or fractured bones or dislocated joints?	☐	☐	52.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
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?	☐	☐	53.	What is the date of your last Tetanus immunization? Date: _____		
22.	Have you ever had a stress fracture?	☐	☐		FEMALES ONLY		
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?	☐	☐	54.	Have you ever had a menstrual period?	☐	☐
				55.	Age when you had your first menstrual period?		
24.	Do you regularly use a brace or assistive device?	☐	☐	56.	How many periods have you had in the last 12 months? _____		
25.	Have you ever been diagnosed with asthma or other allergic disorders?	☐	☐	57.	Do you take a calcium supplement?	☐	☐
26.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐		**Explain "Yes" answers here:**		
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?	☐	☐				

Parent/Guardian Signature:_____

Athlete's Signature:_____

PART III -- PHYSICAL EXAMINATION

NAME:_____ SCHOOL:_____

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

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

*Percent Body Fat: _____

*Audiogram _____

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

Uncorrected (L) _____ (R) _____ (Both)_____

BP:_____

Pulse: *(rest) _____

*(Exercise) _____

*(Recovery) _____

*FEV or Peak Flow (rest) _____

*(Exercise) _____

*(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_____