PHYSICAL EXAMINATION AND PARENT PERMIT FOR ATHLETIC PARTICIPATION

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.**

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

TO BE COMPLETED BY STUDENT AND/OR PARENT

HISTORY

Date _____ Personal Physician _____

Name _____ Sex ___ Age ___ Date of birth _____

Explain "Yes" answers below:

1.	Have you ever been hospitalized?	Yes [ ]	No [ ]
	Have you ever had surgery?	Yes [ ]	No [ ]
2.	Are you presently taking any medications or pills?	Yes [ ]	No [ ]
3.	Do you have any allergies (medicine, bees or other stinging insects)?	Yes [ ]	No [ ]
4.	Have you ever passed out during or after exercise?	Yes [ ]	No [ ]
	Have you ever been dizzy during or after exercise?	Yes [ ]	No [ ]
	Have you ever had chest pain during or after exercise?	Yes [ ]	No [ ]
	Do you tire more quickly than your friends during exercise?	Yes [ ]	No [ ]
	Have you ever had high blood pressure?	Yes [ ]	No [ ]
	Have you ever been told that you have a heart murmur?	Yes [ ]	No [ ]
	Have you ever had racing of your heart or skipped heartbeats?	Yes [ ]	No [ ]
	Has anyone in your family died of heart problems or a sudden death before age 50?	Yes [ ]	No [ ]
5.	Do you have any skin problems (itching, rashes, acne)?	Yes [ ]	No [ ]
6.	Have you ever had a head injury?	Yes [ ]	No [ ]
	Have you ever been knocked out or unconscious?	Yes [ ]	No [ ]
	Have you ever had a seizure?	Yes [ ]	No [ ]
	Have you ever had a stinger, burner or pinched nerve?	Yes [ ]	No [ ]
7.	Have you ever had heat or muscle cramps?	Yes [ ]	No [ ]
	Have you ever been dizzy or passed out in the heat?	Yes [ ]	No [ ]
8.	Do you have trouble breathing or do you cough during or after activity?	Yes [ ]	No [ ]
9.	Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)?	Yes [ ]	No [ ]
10.	Have you had any problems with your eyes or vision?	Yes [ ]	No [ ]
	Do you wear glasses or contacts or protective eye wear?	Yes [ ]	No [ ]
11.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated or other injuries of any bones or joints?	Yes [ ]	No [ ]
	[ ] Head [ ] Shoulder [ ] Thigh [ ] Neck [ ] Elbow [ ] Knee [ ] Chest [ ] Foot		
	[ ] Forearm [ ] Shin/calf [ ] Back [ ] Wrist [ ] Ankle [ ] Hip [ ] Hand		
12.	Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?	Yes [ ]	No [ ]
13.	Have you had a medical problem or injury since your last evaluation?	Yes [ ]	No [ ]
14.	When was your last tetanus shot?	_____	
	When was your last measles immunization?	_____	
15.	When was your first menstrual period?	_____	
	When was your last menstrual period?	_____	
	What was the longest time between your periods last year?	_____	

Explain "yes" answers:

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct. Date _____

Signature of athlete _____

Signature of parent/guardian _____

TO BE COMPLETED BY PHYSICIAN'S OFFICE

PHYSICAL EXAMINATION

NAME_____ **AGE**_____ **DATE OF BIRTH**_____

Height _____ Weight _____ BP _____/_____ Pulse_____G

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils_____G

COMPLETE / **LIMITED**

	Normal	Abnormal Findings	Initials
Cardiopulmonary			
Pulses			
Heart			
Lungs			
Tanner stage	1 2 3 4 5		
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

CLEARANCE

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: _____

C. Not cleared for: [ ] Collision
[ ] Contact
[ ] Non-contact ___ Strenuous ___ Moderately strenuous ___ Non-strenuous

RECOMMENDATION: _____

_____

_____

NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR:

_____

ADDRESS _____ **PHONE**_____

SIGNATURE OF MD/DO, PA, NP, DC-SPC# _____

DATE_____