



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 _____

C O M P L E T E	L I M I T E D	Height _____ Weight _____ BP _____ / _____ Pulse _____ G		
		Vision R 20/_____ L 20/_____ Corrected: Y N Pupils _____ G		
		Normal	Abnormal Findings	Initials
	C O M P L E T E	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 _____