



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.

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

NAME: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

\*Trainer Stage or Maturation Index? (males only): \_\_\_\_\_

\*Percent Body Fat: \_\_\_\_\_

\*Audiotape \_\_\_\_\_

\*Vision: Corrected: (L) \_\_\_\_\_ (R) \_\_\_\_\_ (Both) \_\_\_\_\_

Uncorrected: (L) \_\_\_\_\_ (R) \_\_\_\_\_ (Both) \_\_\_\_\_

Pulse: \*(rest) \_\_\_\_\_

\*(Exercise) \_\_\_\_\_

\*(Recovery) \_\_\_\_\_

\*FEV or Peak Flow (rest) \_\_\_\_\_

\*(Exercise) \_\_\_\_\_

\*(Recovery) \_\_\_\_\_

	N	Abnormal	N	Abnormal
Eyes				
Ears				
Nose				
Throat				
Teeth				
Skin				
Lungs				
Heart				
Peripheral pulses				
Abdomen				
Genitalia/hermia (male only)				
Cervical Spine/neck				
Back				
Shoulders				
Arm/elbow/wrist/hand				
Knees/hips				
Ankles/feet				
Marfan Screen				
*Urine				
*Hemoglobin or HCT and or Iron stores				
^Echocardiogram				
^Neurophysc Testing				
^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: Reason(s): \_\_\_\_\_

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: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Athlete's Signature: \_\_\_\_\_