



# 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 \_\_\_\_\_

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