# PLEASE RETURN TO YOUR COACH MUST BE COMPLETE BEFORE THE FIRST PRACTICE

- 1. PHYSICAL FORM SIGNED BY A PHYSICIAN OR PHYSICIAN'S ASSISTANT ON THE BACK SIGNED BY YOU AND A PARENT ON THE FRONT AND BACK. (Please use the form provided)
- 2. INSURANCE WAIVER SIGNED BY A PARENT OR GUARDIAN OR IF PURCHASING INSURANCE THROUGH THE SCHOOL FORMS ARE AVAILABLE IN THE OFFICE. YOU MUST DO THIS BEFORE THE START OF PRACTICE.
- 3. WARNING LETTER TO STUDENTS AND PARENTS SIGN AND RETURN ONE COPY YOU MAY KEEP THE SECOND COPY.
- 4. EXTRA CURRICULAR PARTICIPATION RULES SIGN AND RETURN ONE COPY YOU MAY KEEP THE SECOND COPY.
- 5. PARENTAL CONSENT FORM FOR MEDICAL TREATMENT TO BE FILLED OUT AND SIGNED BY A PARENT OR GUARDIAN.



## PHYSICAL EXAMINATION AND PARENT PERMIT FOR ATHLETIC PARTICIPATION - PART I

	t was found physically f		ol sports (except as listed on back).	
Studen	t's birth date	Exp. [	Date (good for 365 days)	_
hazardo INTERS FROM	us in which any student SCHOLASTIC ATHLETIC MINOR TO LONG-TERM	will engage in or out of s S INCLUDES A RISK OF	ic athletics and activities may be one of the least school, <b>BY ITS NATURE, PARTICIPATION IT</b> * INJURY WHICH MAY RANGE IN SEVERITY. Although serious injuries are not common	IN TY
			L PHYSICAL PROBLEMS TO THEIR COACHE SPECT THEIR OWN EQUIPMENT DAILY.	:S,
STUDE SIGN T shared	NTS WHO DO NOT WISI HIS PERMISSION FORM	H TO ACCEPT THE RISKS I 1. By signing this form it a cal staff when necessary i	e read and understood this warning. PARENTS OF DESCRIBED IN THIS WARNING SHOULD NO allows my students medical information to lin compliance with HIPPA (Health Insurance)	OT be
High Sc	hool in Colorado High Scho	ool Activities Association appr	_to compete in athletics for proved sports, except as listed on back, and I ha lined in the <i>Competitor's Brochure</i> .	_ ive
Parent o	or Guardian Signature		Date	
I have r	ead, understand and agree	to the General Eligibility Guid	delines as outlined in the Competitor's Brochure.	
Student	Signature		Date	_
No stud principa an adeq assistan	ent shall represent their s I a statement signed by his wate physical examination t, nurse practitioner or a	school in interschool athletics parent or legal guardian and within the past year, that in certified/registered chiroprac	es until there is on file with the superintendent dasigned physical certifying that he/she has passe the opinion of the examining physician, physician ctor, he/she is physically fit to participate in highest or legal guardian to participate.	or ed n's
NOTE:	events have current teta	nus boosters. Tetanus boos	ent of Health that individuals participating in athle sters are recommended every 10 years througho if more than five years have elapsed since the la	out
If signifi conductor practitio	ed. The physical examinat	and/or injuries have occurred ion form must be signed by a	d, a more complete physical examination should be a practicing physician, physician assistant, or nur	be se
If a stu	dent athlete has been in n, the student athlete shou	njured in practice and/or co uld not be permitted to retur	ompetition, the nature of which required medic arn to practice and/or competition until he/she ha	cal as

PHYSICIAN SIGNATURE REQUIRED ON BACK

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.

received a release from a practicing physician.

PART 11 -- 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.

SS. Age when you had your first meastrual period?  S6. How many periods have you had in the last 12  S7. Do you lake a calclum supplement?  Explain "Yes" answers heres:
55.
57, 56, 55,
57. 56. S.
27 28 27
55. 56.
55.
55.
54. Have you ever had a menstrual period?
☐ FEMALES ONLY
53.
Do you have any concerns that you would like discuss with a doctor?
51. Has anyone recommended you change your weight or eating habits?
50. Do you limit or carefully control what you eat?
+
Do you wear protective eyewear, such as goggles a face shield?
(1) 46. Do you wear glasses or contact lenses?
45. Have you had any problems with your eyes or vision?
44. Have you had any other blood disorders or amenia?
Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
42. When exercising in heat, do you have severe muscle cramps or become III?
41. Have you ever been unable to move your arms or legs after being hit or falling?
40. Have you ever had numbriess, tingling, or weakness in your arms or legs after being hit or failing?
39. Do you have headaches with exercise?
38. Have you ever had a seizure?
37. Have you ever been knacked unconscious?
Have you ever been hit in the head and bean confused or lost your memory?
35. Date of last head injury or concussion:
34. Have you ever had a head injury or concussion?
33. Have you ever had herpes skin infection?
32. Do you have any rashes, pressure sores, or o skin problems?

Athlete's Signature:\_

Parent/Guardian Signature:\_

NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR and degree: (print):

Date Signed:

State

Zip

MD/DO, PA, NP, DE-SPC#, Signature:

Date of Examination:

## PART III -- PHYSICAL EXAMINATION

0		0				recomme	I have re	^WITH S (These sto before ma	*WHEN I	Genitalia/hemia	Abdomen	Peripheral pulses	Heart	Lungs	Lymphatic	Skin	Teeth	Throat	Nose	Ears	Eyes		Uncorn	* Vision: Corrected: (L)		*Audiogram_	*Percent Body Fat:	*Tanner Stage	HEIGHT:	in the second
Other Recom	Reason(s):	NOT CLEARED	Cleare	Cleared for	Cleared Al	indations CLEARED	viewed th	PECIAL I Idles may t king partic	JEDICALI Judgment	OJ.			_	-								N	Uncorrected (L) _	cted: (L)			Fat:	or Matura		
Other Recommendations:  Recommend monitoring duri	n(s):	NOT CLEARED FOR PARTICIPATION:	Cleared only for (specific sports):	r Limited participati	Cleared AFTER further evaluation or treatment for:	recommendations for his/her participation in athletics.	e data above, revie	WITH SPECIAL INDICATIONS (These studies may be recommended to the before making participation decision.)	e only)  *WHEN MEDICALLY INDICATED  (Physician judgment based on history, exai			Q.										Abnormal	(R)	(R)	×			*Tanner Stage or Maturation Index? (males only):	WEIGHT:	
er Recommendations: Recommend monitoring during early conditioning because of weight/fitness/other Recommend meta-tellons or monitoring of weight-horse and weight/fitness/other		PATION:	orts):	Cleared for Limited participation (check and explain "reason" for all that apply):	n or treatment for:	ation in athletics.	I have reviewed the data above, reviewed his/her medical history form and make the following	<ul> <li>WITH SPECIAL INDICATIONS</li> <li>(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.)</li> </ul>	le only)  *WHEN MEDICALLY INDICATED  (Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)	^Pelvic Examination	^Neuropsyc Testing	^Echocardlogram	*Hemoglobin or HCI and or Iron stores	*Urine	Martan Screen	Ankle/feet	Knees/hlps	Arm/elbow/wrlst/hand	Shoulders	Back	Cervical Spine/neck		(Both)	(Both)		20 00 00 00 00 00 00 00 00 00 00 00 00 0	ľ	īy):	SEX:	
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ss/other				pply):			nake the following	ngs and may or may not	nd laboratory evaluations													Abnormal	(1000)	*(Exercise)	Flow (rest)	*(Recovery)	Pulse: *(rest) *(Exercise)	BP:	DOB:	

#### KIT CARSON SCHOOL DISTRICT ATHLETIC INSURANCE WAIVER

This statement releases Kit Carson School District R-1 schools of responsibility in case of accident to my son/daughter while he/she is participating in interscholastic activities.

I fully understand that the Kit Carson School District R-1 does not provide accident or health insurance coverage for my son/daughter while he/she is participating in intersholastic activities. However, such insurance is made available by Kit Carson School District through an authorized agent. I further understand that it is my responsibility to provide accident insurance coverage for my son/daughter. Student or Students Name(s) 1. I feel that my present insurance coverage is adequate: Signature Date -OR-2. I am purchasing student accident insurance for my son/daughter through the authorized agent approved by the Board of Education of Kit Carson School District R-1:

Date

Signature

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#### WARNING TO ATHLETES AND PARENTS OR GUARDIANS

SERIOUS, CATASTROPHIC, AND PERHAPS FATAL INJURY MAY RESULT FROM ATHLETIC PARTICIPATION.

By its very nature, competitive athletics may put students in situations in which <u>SERIOUS</u>, <u>CATASTROPHIC</u>, and perhaps, <u>FATAL</u> accidents may occur.

Many forms of athletic competition result in violent physical contact among players, the use of equipment which may result in accidents, strenuous physical exertion, and numerous other exposures to risk of injury.

Students and parents must assess the risks involved in such participation and make their choice to participate in spite of those risks. No amount of instruction, precaution, or supervision, will totally eliminate all risk of injury. Just as driving an automobile involves choice of risk, athletic participation by high school and jr. high students also may be inherently dangerous. The obligation of parents and students in making this choice to participate cannot be over-stated. There have been accidents resulting in death, paraplegia, quadriplegia, and other very serious permanent physical impairment as a result of athletic competition.

By granting permission for your student to participate in athletic competition, you, the parent or guardian, acknowledge that such risk exists.

By choosing to participate, you, the student, acknowledge that such risk exists.

Students will be instructed in proper techniques to be used in athletic competition and in the proper utilization of all equipment worn or used in practice and competition. Students <u>must</u> adhere to that instruction and utilization and <u>must</u> refrain from improper uses and techniques.

As previously stated no amount of instruction, precaution, and supervision will totally eliminate all risk of serious, catastrophic, or even fatal injury.

If any of the foregoing is not completely understood, please contact your school athletic director or superintendent for further information.

Information: Sign both copies, retain one for your records and return the other to the school.

Student's Name\_\_\_\_\_\_\_ Sport(s)\_\_\_\_\_\_\_

This will acknowledge that we have read and understand the material contained in the NOTICE TO ATHLETES AND PARENTS OR GUARDIANS.

Signed\_\_\_\_\_\_\_ Date\_\_\_\_\_\_

Parent or Guardian

Signed\_\_\_\_\_\_ Date\_\_\_\_\_\_

Student

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Signed Parent or Guardian	Date				
SignedStudent	Date				

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#### KIT CARSON R-1 EXTRA CURRICULAR PARTICIPATION RULES

*	Use of alcoholic beverages, toba substances will result in dismissa		ermitted. Use of these
	Curfew is as follows:	Week nights Night before a game	10:30 p.m. 9:00 p.m.
	You are expected to be at practic coach prior to practice excusing		ave received permission from
•	Appearance shall be suitable. B natural un-dyed color. Girls may authority to determine whether a	highlight their hair, but co	aches still retain the ultimate
*	You will be expected to dress in both home and away contests. Yethis area prior to the start of	Your coaches will inform y	
•	Be someone that you, your famil all times. Anything done to discr interests in mind and is a detrime	edit any of the above does	
SIGN	ATURE OF PLAYER	***************************************	DATE
	ATURE OF PARENT/RDIAN		DATE
SIGN	ATURE OF COACH		DATE

**BOARD ADOPTED 5/17/99** 

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(iii	Be someone that you, your familall times. Anything done to discinterests in mind and is a detrime	redit any of the above doe:	community can be proud of at sn't have the team's best
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**BOARD ADOPTED 5/17/99** 

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KIT CARSON SCHOOL ATHLETI	C EMERGENCY/CONSENT FORM				
NAME OF STUDENT:					
PARENT/GUARDIAN:					
HOME ADDRESS:					
PHONE: HOME ()					
EMERGENCY NUMBER IF NOT AT HOME O	R WORK: ()				
INSURANCE COMPANY:	POLICY#:				
FAMILY DOCTOR:					
(1)	PHONE: ()				
(2)	PHONE: ()				
I,					
Date ,	Signature of Parent/ Guardian				

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