



PHYSICAL EXAMINATION AND PARENT PERMIT FOR ATHLETIC PARTICIAPTION

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 OF 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 INTER-SCHOOLASTIC 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 Darren Patterson Christian Academy's approved sports, except as listed on back, and I have read and understand the general guidelines for eligibility as outlined in the Parent-Student Handbook.

Parent or Guardian Signature _____ Date _____

I have read, understand and agree to the DPCA Athletic Standards, Eligibility Guidelines and FRCAA Rules as outlined in the DPCA Parent-Student Handbook.

Student Signature _____ Date _____

No student shall represent DPCA in interschool athletics until there is on file with the Athletic Director 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 of 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 that 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's 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.

PHYSICIAN SIGNATURE REQUIRED SECOND PAGE

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 ()
7. Have you ever had a stinger, burner or pinched nerve? Yes () No ()
- Have you ever had heat or muscle cramps? Yes () No ()
8. Have you ever been dizzy or passed out in the heat? Yes () No ()
9. Do you have trouble breathing or do you cough during or after activity? Yes () No ()
- 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 () Foot
 () Forearm () Shin/ calf () Back () Wrist () Ankle () Hip () Hand
 () Hand () Chest ()
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
Normal		Abnormal Findings			
Cardiopulmonary					Initials
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 _____

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

PHONE _____

DATE: _____