Student ID: _____

WELD COUNTY SCHOOL DISTRICT SIX

Medical History and Physical Examination

Physical Examination Must be Completed and Signed on **Reverse Side** by Your Medical Doctor, (M.D.) Doctor of Osteopathy, (D.O.) Nurse Practitioner, (NP) Physician's Assistant - Certified (PA-C) or Chiropractor (D.C.) Spc #: _____ (Spc. #)

Name: _____ (First, M.I., Last) Date of Birth: ____/____/____ (month/day/year)

Parents/Guardians: _____ (First,Last) Phone: (___) ___ - ____ Alt. Phone: (___) ___ - ____ cell/wk

Address: _____ (Street) School: _____ Grade: _____

_____ (City, State, Zip) Health care provider: _____ (Name)

Form completed by: _____ (Name)

PARENT: Please complete this side of form prior to physical exam.

If your child has had any of the following diseases, record the year.

_____ (year)	_____ (year)	_____ (year)	_____ (year)	_____ (year)	_____ (year)
Rubella (3·Day)	Whooping Cough	Chicken Pox	Pneumonia	Rheumatic Fever	Infections

Current Status of Child's Health:

1. Describe any significant medical or health problems (asthma, diabetes, epilepsy, heart condition, kidney problem, etc.): _____ _____.
2. Is child currently taking any prescription medications, non-prescription medications or inhaler?
   Yes ☐ No ☐ What?_____.
3. Has child ever passed out or been dizzy during or after exercise? Yes ☐ No ☐ If YES, when? _____.
   Describe_____.
4. Has any family member or relative died of heart problems or of sudden death before age 50?
   Yes ☐ No ☐ Who?_____.
5. Has your child ever been referred to health care provider for bone, joint, or muscle problem?
   Yes ☐ No ☐ Results_____.
6. Has your child ever been referred to health care provider for vision problem? Yes ☐ No ☐
   When?_____.
7. Has your child ever been referred to dentist for dental care? Yes ☐ No ☐ If YES, when? _____.
8. Has your child ever used an inhaler? Yes ☐ No ☐
9. Does your child use any special corrective or protective equipment (glasses, contact lens, teeth braces, hearing aids, prosthesis - artificial eye, tooth, limb, etc.)? Yes ☐ No ☐ If YES, what? _____.
10. Has your child ever had any of the following concerns?

Hearing difficulty	Yes ☐	No ☐	Physical limitations	Yes ☐	No ☐
Speech problems	Yes ☐	No ☐	Allergies	Yes ☐	No ☐
Serious injuries	Yes ☐	No ☐	Head injuries	Yes ☐	No ☐
Operations	Yes ☐	No ☐	Hospitalizations	Yes ☐	No ☐

Explain YES answers here:_____

_____

Parent/Guardian Permit for Student Participation

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 NATIJRE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC.** Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate this risk.

Participants can and have the responsibility to help reduce the chance of injury. **PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEM OWN EQUIPMENT DAILY.**

By signing the 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 _____ (First, M.I., Last) to compete in athletics for to compete in athletics for (name of school) _____ School in Colorado High School Activities Association Approved Sports except those crossed out below:

Baseball	Cross Country	Golf	Cheerleading	Soccer	Swimming	Track and Field	Volleyball
Basketball	Football	Gymnastics	Poms	Softball	Tennis	Wrestling	

I understand my child cannot participate in athletics unless he/she is covered by the school accident coverage plan, at my expense, or the equivalent in a family insurance policy. I certify that he/she is in compliance with this regulation.

Date: ____/____/____ (month/day/year) Signature Parent/Guardian: _____ (Signature)

NOTE: THIS STATEMENT MUST BE ON FILE IN THE ATHLETIC OFFICE FOR EVERY STUDENT PARTICIPATING IN INTERSCHOLASTIC ATHLETIC COMPETITION. EQUIPMENT WILL NOT BE ISSUED UNTIL THIS FORM IS RETURNED TO THE COACH OF THIS SPORT.

To be completed by Health Care Provider **PHYSICAL EXAMINATION**

	Normal	Abnormal	Explanation
General Appearance			
Skin			
Eyes			
E-N-T			
Teeth			
Neck			
Chest			
Heart			
Abdomen			
Genitalia			
Extremities			
Spine			
Neurological			
Allergies			
Endocrine			
Laboratory: Urinalysis			
Blood Count			

IMMUNIZATIONS GIVEN TODAY: _____

Dates of MMR (1): ___/___/___. (2): ___/___/___. Hepatitis-B (I): ___/___/___. (2): ___/___/___. (3): ___/___/___.

Varicella: ___/___/___. Hepatitis A: ___/___/___. Other: _____ Date: ___/___/___.

Weight: _____(pounds) Height: _____feet _____inches Blood Pressure: _____/_____.

Is there any history of birth injury, head injury, abnormal growth or development, or history of congenital defects in this child or family?

_____.

Recommendations to School Health Services or other personnel. Any precautions or restrictions?_____

_____.

HEALTH CARE PROVIDER'S CERTIFICATION OF EXAMINATION

I hereby certify that I have examined _____(First, M.I., Last) on ____/____/____(month/day/year).

Signature: _____(Signature) Stamp/Print Name: _____(Name)

HEALTH CARE PROVIDER'S CERTIFICATION FOR ATHLETIC PARTICIPATION

I hereby certify that I have examined _____(First, M.I., Last). Student is:

- ☐ Cleared for all sports.
- ☐ Cleared after completing evaluation/rehabilitation for: _____
- ☐ NOT cleared for (please circle):

Baseball	Basketball	Cross Country	Football	Gymnastics	Cheerleading
Poms	Soccer	Softball	Tennis	Track/Field	Wrestling
Golf	Swimming	Volleyball			

Reason:_____

Recommendations:_____

Name of Health Care Provider (print/type): _____(Name) Date: ____/____/____(month/day/year)

Address:_____(Street) Phone: (____) ____-_____ office

_____(City, State, Zip)

Signature of HCP: _____(Signature) M.D., D.O., NP, PA-C, D.C. Spc#: _____(Spc. #)

(Valid for 365 days unless rescinded)

ADAPTED: American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy of Sports Medicine.