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 #_____.

Name_____ Date of Birth_____
Parents/Guardians_____ Phone_____
Address_____ School_____ Grade_____
Form completed by_____ Health care provider_____

PARENT: Please complete (AND SIGN) this side of form prior to physical exam.

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

_____ _____ _____ _____ _____ _____ _____
Rubella (3-Day) Whooping Cough Chicken Pox Bronchitis 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 your child ever used an inhaler? Yes_____ No_____
4. Has child ever passed out or been dizzy during or after exercise? Yes_____ No_____ When?_____
   Describe_____
5. Has any family member or relative died of heart problems or of sudden death before age 50?
   Yes_____ No_____ Who?_____
6. Has your child ever been referred to health care provider for bone, joint, or muscle problem?
   Yes_____ No_____ Results_____
7. Has your child ever been referred to health care provider for vision problem? Yes_____ No_____
   Concerns:_____
8. Has your child ever been referred to dentist for dental care? Yes_____ No_____ When?_____
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_____ 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 in Middle School/ High School Athletics

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. 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 THEIR 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 _____ to compete in athletics for GREELEY WEST HIGH SCHOOL, in Colorado High School Activities Association Approved Sports except those crossed out below:

Baseball, basketball, cross country, football, golf, gymnastics, cheerleading, poms, soccer, softball, swimming, tennis, track and field, wrestling, volleyball.

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:_____ Signature Parent/Guardian_____

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 (1)_____ (2)_____ (3)_____

Varicella_____ Hepatitis A_____ Other_____

Weight:_____ Height:_____ 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 _____ on _____(date).

Signature_____ **Stamp/Print Name**_____

For Middle/ High School Sports Only

HEALTH CARE PROVIDER'S CERTIFICATION FOR MIDDLE/ HIGH SCHOOL ATHLETIC PARTICIPATION

I hereby certify that I have examined _____. 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) _____ _____Date_____

Address_____Phone_____

Signature of HCP_____ M.D., D.O., NP, PA-C, D.C. Spc#_____

(Valid for 365 days unless rescinded)

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

NS211/01