# Craig Middle School Athletic Permission Form

Name _____ Address _____

Date of Birth _____ Age _____ Sex _____ Grade _____ Phone _____

Sports played _____ _____ _____ _____ _____

Is this student new in Moffat County School District? Yes _____ No _____

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. By signing this form it allows my student's medical information to be shared with the appropriate staff when necessary in compliance with HIPPA (Health Insurance Portability and Accountability Act) regulations.**

**PARENT/GUARDIAN'S PERMISSION TO PARTICIPATE AND TRAVEL** I hereby give my consent for the above-named student to (1) represent his/her school in athletic activities except those limitations noted on this form by the examining physician provided that such athletic activities are approved by the State Association and (2) accompany any school team of which he/she is a member on any of its local or out-of-town trips. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become necessary for the above-named student in the course of such athletic activities or such travel. I also agree not to hold the school or anyone acting on its behalf responsible for any injury occurring to the above-named student in the course of such athletic activities or such travel.

Signature of Parent /Guardian _____ Date _____

**HEALTH HISTORY** Personal Physician _____ Phone _____

Address _____

Explain "YES" answers below

YES NO

_____ _____ Have you ever been hospitalized?

_____ _____ Are you presently taking any medications or pills?

_____ _____ Have you ever passed out during or after exercise?

_____ _____ Have you ever been dizzy during or after exercise?

_____ _____ Do you tire more quickly than your friends during exercise?

_____ _____ Have you ever been told that you have a heart murmur?

_____ _____ Has anyone in your family died of heart problems or sudden death before age 50?

_____ _____ Have you ever been knocked out or unconscious?

_____ _____ Have you ever had a stinger, burner, or pinched nerve?

_____ _____ Have you ever been dizzy or passed out in the heat?

_____ _____ Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?

_____ _____ Do you wear glasses or contacts or protective eye wear?

_____ _____ Have you ever had surgery?

_____ _____ Do you have any allergies (medicine, bees or other stinging insects)?

_____ _____ Have you ever had chest pain during or after exercise?

_____ _____ Have you ever had high blood pressure?

_____ _____ Have you ever had racing of your heart or skipped heartbeats?

_____ _____ Do you have any skin problems (itching, rashes, acne)?

_____ _____ Have you ever had a head injury?

_____ _____ Have you ever had a seizure?

_____ _____ Have you ever had heat or muscle cramps?

_____ _____ Do you have trouble breathing or do you cough during or after activity?

_____ _____ Have you had any problems with your eyes or vision?

_____ _____ Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bone or joints?

☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Elbow ☐ Knee ☐ Chest ☐ Foot

☐ Forearm ☐ Shin/calf ☐ Back ☐ Wrist ☐ Ankle ☐ Hip ☐ Hand

_____ _____ Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?

_____ _____ Have you had a medical problem since your last evaluation?

When was your last Tetanus shot? _____When was your last Measles immunization? _____

Dates of Hepatitis B series: (1) _____ (2) _____ (3) _____

**EXPLAIN "YES" ANSWERS** _____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Parent /Guardian _____ Date _____

**PROOF OF INSURANCE** In order to participate in Moffat County School District Athletics your student must have medical insurance to cover any injuries which may occur. Please enter your insurance information below. A supplemental insurance plan is available through the school.

My student is covered by _____ Policy Number _____

_____ I desire school insurance for my student. Information and forms for school insurance will be available from school prior to the start of the school sports season. Cost varies depending on desired coverage.

Your signature indicates you have adequate insurance and are responsible for any deductible required by your insurance company.

Signature of Parent /Guardian _____ Date _____

**PARENTAL CONSENT FOR PHYSICAL EXAMINATION** I hereby give my consent for the above-mentioned student to receive a physical and, to the best of my knowledge, the answers to the above questions are correct. I understand that the examination given by the physician, which both the school and parents/guardians accept and approve, is a limited physical examination. I understand and accept there are further physical examination criteria that can be obtained if I am willing to accept responsibility and expense thereof. I further understand that subsequent illness or injury will not be the responsibility of the examining physician due to the limited nature of this examination.

Signature of Parent /Guardian _____ Date _____

NOTE: According to CHSAA, a physical form must be signed (also include the stamp of the person providing the physical) by a medical doctor licensed to practice in Colorado, a nurse practitioner, a physician's assistant, or doctors of chiropractic who are School Physical Certified (DC, Spc.).

**PHYSICAL EXAMINATION** OF: _____ Date of Birth _____ Age _____

LIMITED

COMPLETE

Height _____ Weight _____ BP _____/_____ Pulse _____

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils _____

| | Normal | Abnormal Findings | Initials |
|---|---|---|---|
| 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

Due to: _____

Recommendation: _____

_____

Name of Physician: _____ Address: _____

Signature of Physician: _____ Phone: _____ Date: _____