PARENT OR GUARDIAN PERMIT FOR ATHLETIC 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 NATURE, PARTICIPATION IN INTERSCHOLASTIC 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. By signing this form it allows my student's medical information to be shared with appropriate medical staff when necessary in compliance with HIPPA (Health Insurance Portability and Accountability Act) Regulations.**

I hereby give my consent for _____ to compete in athletics for _____ High School in Colorado High School Activities Association approved sports, except as listed on back, and I have read and understand the general guidelines for eligibility as outlined in the CHSAA *Competitor's Brochure.*

Parent or Guardian Signature _____ Date _____

I have read, understand and agree to the General Eligibility Guidelines as outlined in the CHSAA *Competitor's Brochure.*

Student Signature _____ Date _____

NO STUDENT SHALL REPRESENT THEIR SCHOOL IN INTERSCHOOL ATHLETICS UNTIL THERE IS A STATEMENT ON FILE WITH THE SUPERINTENDENT OR PRINCIPAL SIGNED BY HIS/HER PARENT OR LEGAL GUARDIAN AND A SIGNED PHYSICAL FORM CERTIFYING THAT HE/SHE HAS PASSED AN ADEQUATE PHYSICAL EXAMINATION WITHIN THE PAST YEAR, NOTING THAT IN THE OPINION OF THE EXAMINING PHYSICIAN, PHYSICIAN'S ASSISTANT, NURSE PRACTITIONER OR A CERTIFIED/REGISTERED DOCTORS OF CHIROPRACTIC THAT ARE SCHOOL PHYSICAL CERTIFIED, IS PHYSICALLY FIT TO PARTICIPATE IN HIGH SCHOOL ATHLETICS; THAT STUDENT HAS THE CONSENT OF HIS/HER PARENTS OR LEGAL GUARDIAN TO PARTICIPATE; AND, THE PARENT AND PARTICIPANT HAVE READ, UNDERSTAND AND AGREE TO THE CHSAA GUIDELINES FOR ELIGIBILITY.

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 than 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 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.

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.

CHSAA RECOMMENDS the American Academy of Pediatrics preparticipation physical evaluation forms for a more comprehensive preparticipation evaluation. Follow the links provided for access to the AAP's forms.

History Form The Athlete with Special Needs: Supplemental History Form Physical Examination Form Clearance Form

PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

4

Revised 4/24

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Gender: _____ Age: _____ Date of Birth: ___/___/_____
School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____ Home Phone: (_____) _____
Name of Parent/Guardian: _____ E-mail: _____
Person to Contact in Case of Emergency: _____ Relationship to Student: _____
Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____
Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

_____

I hereby certify that I have examined the above-named student-athlete using the CHSAA Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___/___/_____
Address: _____ Phone: (_____) _____
Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

☐ Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp *(if required by school)*

Medications: *(use additional sheet, if necessary)*

List: _____

_____

Relevant medical history to be reviewed by athletic trainer/team physician: *(explain below, use additional sheet, if necessary)*

☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait ☐ Mental Health

Explain: _____

_____

Signature of Student: _____ Date: ___/___/___ Signature of Parent/Guardian: _____ Date: ___/___/___

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct.

This form is not considered valid unless all sections are complete.

PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

1

Revised 4/24

MEDICAL HISTORY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Gender: _____ Age: _____ Date of Birth: ___/___/_____
School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____ Home Phone: (_____) _____
Name of Parent/Guardian: _____ E-mail: _____
Person to Contact in Case of Emergency: _____ Relationship to Student: _____
Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____
Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

List past and current medical conditions:

_____

Have you ever had surgery? If yes, please list all surgical procedures and dates:

_____

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

_____

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

_____

Patient Health Questionnaire version 4 (PHQ-4)

Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)

	Not at all	Several days	Over half of the days	Nearly everyday
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

	GENERAL QUESTIONS Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.	Yes	No
1	Do you have any concerns that you would like to discuss with your provider?		
2	Has a provider ever denied or restricted your participation in sports for any reason?		
3	Do you have any ongoing medical issues or recent illnesses?		
	HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4	Have you ever passed out or nearly passed out during or after exercise?		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7	Has a doctor ever told you that you have any heart problems?		

	HEART HEALTH QUESTIONS ABOUT YOU *(continued)*	**Yes**	**No**
8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10	Have you ever had a seizure?		
	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash)		
12	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Bragada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

2

Revised 4/24

Student's Full Name: _____ Date of Birth: ___ /___ /_____ School: _____

	BONE AND JOINT QUESTIONS	Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		

	MEDICAL QUESTIONS	Yes	No
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?		
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
22	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
23	Have you ever become ill while exercising in the heat?		
24	Do you or does someone in your family have sickle cell trait or disease?		
25	Have you ever had or do you have any problems with your eyes or vision?		

	MEDICAL QUESTIONS *(continued)*	Yes	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that you gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

Explain "Yes" answers here:

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. CHSAA bylaw 1780.1 states, "No pupil shall participate in formal practice or represent his/her/their school in interscholastic athletics until there is a statement on file with the principal or athletic director signed by his/her/their parents or legal guardian and a practitioner licensed in the United States to perform sports physicals certifying that: (a) he/she/they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in high school athletics; and (c) that he/she/they has the consent of his/her/their parents or legal guardian to participate. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. No pupil shall participate in formal practice or represent his/her/their school in interscholastic athletics until this form is completed in its entirety and page 4 is on file with the principal or athletic director signed by his/her/their parents or legal guardian and a practitioner licensed in the United States to perform sports physicals certifying that: (a) he/she/they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in high school athletics. The CHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____*(printed)* Student-Athlete Signature: _____ Date: ___/ ___/ ___

Parent/Guardian Name: _____*(printed)* Parent/Guardian Signature: _____ Date: ___/ ___/ ___

Parent/Guardian Name: _____*(printed)* Parent/Guardian Signature: _____ Date: ___/ ___/ ___

PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ___ /___ /_____ School: _____

PHYSICIAN REMINDERS:

Consider additional questions on more sensitive issues.

• Do you feel stressed out or under a lot of pressure?	• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	
• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?	

☐ Verify completion of Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

EXAMINATION

Height: **Weight:**

BP: / (/) **Pulse:** **Vision:** R 20/ L 20/ **Corrected:** Yes No

MEDICAL - healthcare professional shall initial each assessment	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, Ears, Nose, and Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL - healthcare professional shall initial each assessment	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and Arm		
Elbow and Forearm		
Wrist, Hand, and Fingers		
Hip and Thigh		
Knee		
Leg and Ankle		
Foot and Toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

Name of Healthcare Professional (print or type): _____ Date of Exam: ___/ ___/ _____

Address: _____ Phone: (____) _____ E-mail: _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____