ACTIVIDADES /ATLETISMO DE LAS ESCUELAS DE FORT MORGAN

Nombre del Estudiante: _____ Fecha de Nacimiento: _____ Grado: _____

EXAMEN FÍSICO PARA LA PARTICIPACIÓN EN ATLETISMO

Por la presente certifico que he examinado a este estudiante y que lo encontré físicamente apto para participar en deportes escolares.

Excepciones: _____

Firma del MD/DO, PA, NA, DC-SPC#: _____ Fecha del examen: _____
(Válido por 365 días)

AUTORIZACIÓN PARA TRATAMIENTO DE UN MENOR

Como el padre o tutor legal del estudiante arriba citado, yo doy mi consentimiento para que este menor reciba tratamiento médico de emergencia y cirugía en un hospital autorizado por un Médico con Licencia para ejercer de Colorado en caso de que su condición así lo requiera en mi ausencia.

Entiendo que en un caso así, se harían primero todos los intentos por contactarme—mientras el tiempo y las condiciones lo permitan. Siempre y cuando el tratamiento médico o de cirugía considerado necesario en la situación esté de acuerdo con los estándares o práctica médica aceptados generalmente para el tipo específico de lesión o enfermedad, yo impongo ninguna limitación específica o prohibición referente al tratamiento aparte de las siguientes: _____.

SI usted no tiene seguro médico, por favor contacte a la oficina escolar para información sobre cómo comprar un seguro.

Nombre del Padre / Tutor	Teléfono en el Hogar	Teléfono del Trabajo
Nombre del 2º Contacto	Tel. Hogar del 2º Contacto	Tel. Trabajo del 2º Contacto

Debe incluir la Compañía de Seguros y el número de póliza

Compañía de Seguros

Número de Póliza

ACEPTACIÓN DE RIESGO

AVISO: Aunque la participación en las supervisadas actividades y atletismo inter-escolares podría ser una de las menos riesgosas en las cuales cualquier estudiante se involucre, dentro o fuera de la escuela, ***por su naturaleza, la participación en el atletismo inter-escolar implica un riesgo de lesión que pudiera variar en cuanto a severidad, de una lesión menor hasta una lesión catastrófica a largo plazo.*** Aunque las lesiones serias no son comunes en los supervisados programas de atletismo escolar, es imposible eliminar ese riesgo.

Los jugadores deben de obedecer todas las reglas de seguridad, reportar cualquier problema físico a su entrenador, seguir un programa de acondicionamiento apropiado, e inspeccionar su propio equipo diariamente.

Al firmar este Formulario de Permiso, nosotros aceptamos que hemos leído y entendido este aviso. ***Los padres o alumnos quienes no deseen aceptar el riesgo descrito en este aviso no deben firmar este formulario de permiso.***

Yo entiendo que mi hijo/hija será regido por las reglas y regulaciones del entrenamiento atlético como un participante en las Actividades y Atletismo de las Escuelas de Fort Morgan. También entiendo que nosotros podríamos ser responsables por las cuotas de participación o multas causadas por la pérdida de equipo o artículos deportivos que se hayan prestado a nuestro hijo/hija.

Yo mantengo una adecuada cobertura de seguro para mi hijo/hija que pagará recibos médicos y de hospital que resulten de posibles lesiones adquiridas al momento de su participación en ciertas actividades.

PERMISO DEL PADRE/TUTOR – APROBACIÓN DEL CONTRATO POR EL ESTUDIANTE

Yo, por la presente, doy mi consentimiento para que mi hijo(a) participe en actividades / atletismo ofrecidos por las Escuelas de Fort Morgan. Nosotros (padre y alumno) hemos leído y entendido la información arriba mencionada y estamos de acuerdo en sujetarnos a las reglas y regulaciones de las Escuelas de Fort Morgan.

Firma del estudiante: _____ _____
Fecha

Firma del padre: _____ _____
Fecha

PART II -- MEDICAL HISTORY

This form must be completed and signed, prior to the physical examination, for review by examining physician. Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.

	MEDICAL HISTORY OF STUDENT & FAMILY	YES	NO		MEDICAL HISTORY OF STUDENT & FAMILY	YES	NO
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐	32.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐	33.	Have you ever had herpes skin infection?	☐	☐
3.	Are you currently taking any prescription or non prescription (over the counter) medicines or pills?	☐	☐	34.	Have you ever had a head injury or concussion?	☐	☐
4.	Do you have allergies to medicines, pollens, foods or stinging insects?	☐	☐	35.	Date of last head injury or concussion: _____		
5.	Do you have prescriptions for use of epinephrine, adrenalin, inhaler, or other allergy medications?	☐	☐	36.	Have you ever been hit in the head and been confused or lost your memory?	☐	☐
6.	Have you ever passed out or nearly passed out during or after exercise?	☐	☐	37.	Have you ever been knocked unconscious?	☐	☐
7.	Have you ever passed out or nearly passed out at any other time?	☐	☐	38.	Have you ever had a seizure?	☐	☐
8.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	39.	Do you have headaches with exercise?	☐	☐
9.	Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath?	☐	☐	40.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
10.	Does your heart race or skip beats during exercise?	☐	☐	41.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
11.	Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection			42.	When exercising in heat, do you have severe muscle cramps or become ill?	☐	☐
				43.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
12.	Has a doctor ever ordered a test for your heart?	☐	☐	44.	Have you had any other blood disorders or amenia?	☐	☐
13.	Has anyone in your family died suddenly for no apparent reason?	☐	☐	45.	Have you had any problems with your eyes or vision?	☐	☐
14.	Does anyone in your family have a heart problem?	☐	☐	46.	Do you wear glasses or contact lenses?	☐	☐
15.	Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death.)	☐	☐	47.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
16.	Does anyone in your family have Marfan syndrome?	☐	☐	48.	Are you happy with your weight?	☐	☐
17.	Have you ever spent the night in a hospital?	☐	☐	49.	Are you trying to gain or lose weight?	☐	☐
18.	Have you ever had surgery?	☐	☐	50.	Do you limit or carefully control what you eat?	☐	☐
19.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	☐	☐	51.	Has anyone recommended you change your weight or eating habits?	☐	☐
20.	Have you had any broken or fractured bones or dislocated joints?	☐	☐	52.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
21.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	☐	☐	53.	What is the date of your last Tetanus immunization? Date: _____		
22.	Have you ever had a stress fracture?	☐	☐		FEMALES ONLY		
23.	Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?	☐	☐	54.	Have you ever had a menstrual period?	☐	☐
				55.	Age when you had your first menstrual period?		
24.	Do you regularly use a brace or assistive device?	☐	☐	56.	How many periods have you had in the last 12 months? _____		
25.	Have you ever been diagnosed with asthma or other allergic disorders?	☐	☐	57.	Do you take a calcium supplement?	☐	☐
26.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐		**Explain "Yes" answers here:**		
27.	Is there anyone in your family who has asthma?	☐	☐				
28.	Have you ever used an inhaler or taken asthma medicine?	☐	☐				
29.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐				
30.	Have you had infectious mononucleosis (mono) within the last three months?	☐	☐				
31.	Have you ever had mono or any illness lasting more than two weeks?	☐	☐				

Parent/Guardian Signature:_____

Athlete's Signature:_____

PART III -- PHYSICAL EXAMINATION

NAME:_____ SCHOOL:_____

HEIGHT:_____ WEIGHT:_____ SEX: _____ AGE:_____ DOB: _____

*Tanner Stage or Maturation Index? (males only): _____

*Percent Body Fat: _____

*Audiogram _____

* Vision: Corrected: (L) _____ (R) _____ (Both)_____

Uncorrected (L) _____ (R) _____ (Both)_____

BP:_____

Pulse: *(rest) _____

*(Exercise) _____

*(Recovery) _____

*FEV or Peak Flow (rest) _____

*(Exercise) _____

*(Recovery) _____

	N	Abnormal		N	Abnormal
Eyes			Cervical Spine/neck		
Ears			Back		
Nose			Shoulders		
Throat			Arm/elbow/wrist/hand		
Teeth			Knees/hips		
Skin			Ankle/feet		
Lymphatic			Marfan Screen		
Lungs			*Urine		
Heart			*Hemoglobin or HCT and or Iron stores		
Peripheral pulses			^Echocardiogram		
Abdomen			^Neuropsyc Testing		
Genitalia/hernia (male only)			^Pelvic Examination		

***WHEN MEDICALLY INDICATED**
(Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)

^WITH SPECIAL INDICATIONS
(These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decision.)

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

- ☐ **CLEARED WITHOUT RESTRICTIONS**
- ☐ Cleared **AFTER** further evaluation or treatment for:_____
- ☐ Cleared for **Limited participation** (check and explain "reason" for all that apply):
  - ☐ Not cleared for (specific sports): _____
  - ☐ Cleared only for (specific sports):_____
    Reason(s):_____
- ☐ **NOT CLEARED FOR PARTICIPATION:**_____
  Reason(s):_____
- ☐ Other Recommendations:_____
  - ☐ Recommend monitoring during early conditioning because of weight/fitness/other
  - ☐ Recommend restrictions or monitoring of weight loss or gain
  - ☐ Other: Reasons:_____

MD/DO, PA, NP, DE-SPC#, Signature:_____

Date of Examination:_____ Date Signed:_____

NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR and degree: (print):

_____

Address:_____

City_____ State _____ Zip_____