BENNETT MIDDLE SCHOOL
PHYSICIAN AND PARENT PERMIT FOR ATHLETIC PARTICIPATION

I hereby certify that I have examined ______________________________ and that the student athlete was found physically fit to engage in middle school baseball, basketball, football, track and field, volleyball, and wrestling. (Please circle any sport in which the student athlete should not participate.)

Student's birth date ______________________

Date _________________________________ (Valid for 365 days unless rescinded)

PARENT OR GUARDIAN PERMIT

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 that 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 understand 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 Bennett Middle School of Bennett, Colorado.

Baseball, Basketball, Football, Track and Field, Volleyball, Wrestling, Cheer, and Pom Poms

Date________________ Parent/Guardian Signature ______________________________________

Date ________________ Student Signature ____

No student shall represent their school in interschool athletics until there is on file with the superintendent or principal a statement signed by his/her parent or legal guardian and a signed physical certifying that he/she has passed an adequate physical examination within the past year, that in the opinion of the examining physician, physician's assistant, nurse practitioner or a certified/registered chiropractor, he/she is physically fit to participate in high school athletics and that he/she has the consent of his/her parent or legal guardian to participate.

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's 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.

PHYSICAN SIGNATURE REQUIRED ON BACK

TO BE COMPLETED BY STUDENT AND/OR PARENT

HISTORY

Date ____________ Personal Physician ______________________________

Name ______________________________ Sex ____ Age ____ DOB ________

Explain "Yes" answers below.

1. Have you ever been hospitalized? Yes [ ] No [ ]
   Have you ever had surgery? Yes [ ] No [ ]
2. Are you presently taking any medications or pills? Yes [ ] No [ ]
3. Do you have any allergies (medicine, bees or other stinging insects)? Yes [ ] No [ ]
4. Have you ever passed out during or after exercise? Yes [ ] No [ ]
   Have you ever been dizzy during or after exercise? Yes [ ] No [ ]
   Have you ever had chest pain during or after exercise? Yes [ ] No [ ]
   Do you tire more quickly than your friends during exercise? Yes [ ] No [ ]
   Have you ever had high blood pressure? Yes [ ] No [ ]
   Have you ever been told you have a heart murmur? Yes [ ] No [ ]
   Have you ever had racing of your heart or skipped heartbeats? Yes [ ] No [ ]
   Has anyone in your family died of heart problems or a sudden death before age 50? Yes [ ] No [ ]
5. Do you have any skin problems (itching, rashes, acne)? Yes [ ] No [ ]
6. Have you ever had a head injury? Yes [ ] No [ ]
   Have you ever been knocked out or unconscious? Yes [ ] No [ ]
   Have you ever had a seizure? Yes [ ] No [ ]
   Have you ever had a stinger, burner or pinched nerve? Yes [ ] No [ ]
7. Have you ever had heat or muscle cramps? Yes [ ] No [ ]
   Have you ever been dizzy or passed out in the heat? Yes [ ] No [ ]
8. Do you have trouble breathing or do you cough during or after activity? Yes [ ] No [ ]
9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)? Yes [ ] No [ ]
10. Have you had any problems with your eyes or vision? Yes [ ] No [ ]
    Do you wear glasses or contacts or protective eyewear? Yes [ ] No [ ]
11. Have you ever sprained/strained, dislocated, fractured, broken, or had repeated or other injuries of any bones or joints? Yes [ ] No [ ]
    [ ] Head [ ] Shoulder [ ] Thigh [ ] Neck [ ] Elbow
    [ ] Knee [ ] Chest [ ] Foot [ ] Forearm [ ] Shin/Calf
    [ ] Back [ ] Wrist [ ] Ankle [ ] Hip [ ] Hand
12. Have you had any other medical problems (infectious mononucleosis diabetes, etc.)? Yes [ ] No [ ]
13. Have you had a medical problem or injury since your last evaluation? Yes [ ] No [ ]
14. When was your last tetanus shot? Yes [ ] No [ ]
    When was your last measles immunization? Yes [ ] No [ ]
15. When was your first menstrual period? Yes [ ] No [ ]
    When was your last menstrual period? Yes [ ] No [ ]
    What was the longest time between your period last year? Yes [ ] No [ ]

Explain "Yes" answers: ______________________________

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

Date ____________

Signature of Student Athlete ______________________________

Signature of Parent/Guardian ______________________________

TO BE COMPLETED BY PHYSICIAN'S OFFICE

PHYSICAL EXAMINATION

Name ______________________ Age ____ DOB __________

Height ______ Weight ______ BP ____/____ Pulse __________ G

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

	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

RECOMMENDATION

____

____

____

Name Physician/PA/Nurse Practitioner/Certified Registered Chiropractor

____

Address ______________________________

Phone ______________________________

Signature MD/DO, PA, NA, DC-SPC# ______________________________

Date ____________