



Falcon High School Athletic Participation Form

Please complete form in its entirety or participation may be delayed or denied

SECTION I: ATHLETE INFORMATION

Last Name: _____ First Name: _____ Sport _____ Fall _____ Winter _____ Spring _____

Male _____ Female _____ Age _____ Birth date _____ Grade _____

Parent/Guardian Name: _____ Email: _____

Address: _____ Zip Code: _____ Phone: _____ Cell: _____

Physician: _____ Physician Phone: _____

Hospital Preference: _____ Chronic Ailments: _____

Emergency Contact Person: _____ Emergency Contact Number: _____

SECTION II: TRANSFER INFORMATION

Date you first attended *any* high school _____ Date you started at Falcon High School _____

List any high schools besides Falcon you attended and dates: _____

Did you participate in sports in your previous school? _____

If yes, what sports and level? _____

Section IV: COLORADO HIGH SCHOOL ACTIVITIES STATEMENT FOR PARTICIPATION BY PHYSICIAN

____ Initial physical examination ____ Medical Re-evaluation

I hereby certify that I have examined _____ and that the student was found physically fit to engage in high school baseball, basketball, cross country, football, golf, gymnastics, softball, swimming, tennis, track and field, wrestling, volleyball, soccer, ice hockey, Lacrosse. (Please cross out any sport in which the student should not participate.)

Date: _____ (valid for 365 days unless rescinded.) Physician Signature: _____ (must be signed by a physician)

SECTION V: PARTICIPATION WARNING:

Although participation in supervised interscholastic athletics may not be considered hazardous, **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 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 RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.** By signing this form, we acknowledge that we have read and understood this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THE WARNING SHOULD NOT SIGN THIS PERMISSION FORM.**

I hereby give my consent for _____ to compete in athletics for Falcon High School, in Colorado High School Activities Association approved sports except those crossed out below.

Baseball, Basketball, Cheer, Cross Country, Football, Golf, Softball, Tennis, Track and Field, Wrestling, Volleyball, Soccer

In consideration of my son's/daughter's opportunity to participate in interscholastic activities, I hereby consent to emergency medical treatment, hospitalization or other medical treatment as may be necessary for the welfare of the above named child, by a physician, qualified nurse, and/or hospital, in the event of injury or illness during all periods of time in which the student is away from his/her legal residence as a member of an interscholastic activity team or group, and hereby waive on behalf of myself and the above named child any liability of School District No. 49, any of its agents or employees, arising out of such medical treatment.

DATE: _____ PARENT OR GUARDIAN SIGNATURE _____

DATE: _____ STUDENT SIGNATURE _____

Your signature indicates you have read the District 49 Athletic Handbook/Codes of Conduct and understand the policies. This document can be found at http://www.d49.org/publications/athletic_handbooks/HS_Athletic_Handbook.pdf

OFFICE USE ONLY

Fees: _____ Date Paid: _____ check #: _____ Cash: _____ Received by: _____

Schedule _____ Transcript _____ Semesters _____ Out of district _____ Home-school _____

Physical Date: _____

HISTORY

Date _____ Personal Physician _____ Sex _____ Age _____ Date of birth _____

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
5. Have you ever been dizzy during or after exercise?
 Yes No
6. Have you ever had chest pain during or after exercise?
 Yes No
7. Do you tire more quickly than your friends during exercise?
 Yes No
8. Have you ever had high blood pressure?
 Yes No
9. Have you ever been told that you have a heart murmur?
 Yes No
10. Have you ever had racing of your heart or skipped heartbeats?
 Yes No
11. Has anyone in your family died of heart problems or a sudden death before age 50?
 Yes No
12. Do you have any skin problems (itching, rashes, acne)?
 Yes No
13. Have you ever had a head injury?
 Yes No
14. Have you ever been knocked out or unconscious?
 Yes No
15. Have you ever had a seizure?
 Yes No
16. Have you ever had a stinger, burner or pinched nerve?
 Yes No
17. Have you ever had heat or muscle cramps?
 Yes No
18. Have you ever been dizzy or passed out in the heat?
 Yes No
19. Do you have trouble breathing or do you cough during or after activity?
 Yes No
20. Do you use any special equipment (gads, braces, neck rolls, mouth guard, eye guard, etc.)?
 Yes No
21. Have you had any problems with your eyes or vision?
 Yes No
22. Do you wear glasses or contacts or protective eye wear?
 Yes No
23. Have you ever sprained/strained, dislocated, fractured, broken or had repeated or other injuries of any bones or joints?
 Yes No
24. Head Shoulder Thigh Neck Elbow Knee Chest Foot
 Forearm Shin/knife Back Wrist Ankle Hip Hand
25. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?
 Yes No
26. When was your last tetanus shot?

27. When was your last measles immunization?

28. When was your first menstrual period?

29. What was your last menstrual period?

30. What was the longest time between your periods last year?

Explain "yes" answers:

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

Signature of athlete _____

Signature of parent/guardian _____

PHYSICAL EXAMINATION

NAME _____ AGE _____ DATE OF BIRTH _____

Height	_____	Weight	_____	BP	____/____	Pulse	____
Vision R 20'	_____	L 20'	_____	Corrected	Y N	Pupils	____
Initials	_____	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

RECOMMENDATION:

Non-contact Strenuous Moderately strenuous Non-strenuous

NAME OF PHYSICIAN/PARNRSE PRACTITIONER/CERTIFIED REGISTERED CHIROPRACTOR: _____

ADDRESS _____ PHONE _____

SIGNATURE OF MD/DO, PA, NP, DC-SFC# _____ DATE _____