WELD COUNTY SCHOOL DISTRICT RE-1
MEDICAL HISTORY & PHYSICAL EXAMINATION FORM

STUDENT NAME: _____ DATE OF BIRTH:_____

PARENT/GUARDIAN NAME: _____ SCHOOL: _____

PHYSICAL ADDRESS: _____/_____/_____

City State Zip

MEDICAL TREATMENT RELEASE

I hereby give permission for the coach or other school official to arrange for emergency treatment for the above named student with a physician, EMT, certified athletic trainer or hospital emergency room in the event that I cannot be notified. I understand that the school does not carry insurance for any loss that may be sustained due to injury as a result of athletic participation.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

If you do not give permission or authorization for consent to medical treatment, which procedure should be followed?

_____

INSURANCE COVERAGE

I understand my child cannot participate in athletics unless he/she is covered by the school accident coverage plan or the equivalent in a family insurance policy. Please CHECK (X) and FILL IN one of the following options:

____ We have purchased school accident insurance. Date purchased _____ Policy # _____
(Football players at the HIGH SCHOOL level must purchase additional '*football*' coverage.)

____ We have adequate personal and/or medical insurance to cover any injury that may occur while participating in the interscholastic program.
Company name: _____Policy number:_____

INFORMED CONSENT

WARNING: Although participation is supervised, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS AND ACTIVITIES INCLUDE A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM, CATASTROPHIC, OR EVEN DEATH. Although serious injuries are not common in supervised school programs, it is impossible to eliminate this risk.
Parents/guardians of students who do not wish to accept the risks should not sign this permission form.

By signing this permission form, we acknowledge that we have read and understand this warning.

I HEREBY GIVE MY CONSENT FOR _____ TO COMPETE IN ATHLETICS FOR WELD RE-1 SCHOOLS, IN CHSAA SANCTIONED EVENTS. EXCEPTIONS: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

STUDENT SIGNATURE: _____ DATE: _____

HIGH SCHOOL ATHLETES ONLY: Furthermore, by signing this form we acknowledge that we have filled out the Emergency Contact form as well as the CHSAA and the District Co-Curricular Training rules online and validate the e-signatures provided on those forms.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

STUDENT SIGNATURE: _____ DATE: _____

(To be completed by physician or examining health professional)

NOTE: THIS FORM SHOULD BE ON FILE IN THE AD'S OFFICE FOR EVERY STUDENT PARTICIPATING IN ATHLETIC COMPETITION.

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MEDICAL HISTORY & PHYSICAL EXAMINATION FORM

PHYSICIAN: _____

ADDRESS: _____
City State Zip

	NORMAL	ABNORMAL	EXPLANATION
General Appearance			
Skin			
Eyes			
E-N-T			
Teeth			
Neck			
Chest			
Heart			
Abdomen			
Genitalia			
Extremities			
Spine			
Neurological			
Allergies			
Endocrine			
Lab: Urinalysis			
Lab: Blood Count			

Weight: _____ Height: _____ BP: _____

Are there any medical conditions that coaches need to be made aware of that may affect regular participation in interscholastic athletics and activities? (allergies, asthma, diabetes, epilepsy, etc.) _____

_____

_____

_____

Is there any history of birth injury, head injury, abnormal growth or development, or history of congenital defects in this child of child's family?_____

Recommendations to school or other personnel: _____

_____

I hereby certify that I have examined _____ (student name) and that the student was found physically fit to engage in interscholastic athletics.

List any exceptions here: _____

Signed (physician): _____ Date of Exam: _____

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