

Ellicott 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: SCHOOL DISTRICT 22 ATHLETIC/ACTIVITY INSURANCE WAIVER

This statement releases the District No. 22 schools of responsibility in case of accident to my son/daughter while he/she is participating in interscholastic activities. I fully understand that the District No. 22 schools do not provide accident or health insurance coverage for my son/daughter while he/she is participating in interscholastic activities. I further understand that it is my responsibility to provide accident insurance for my son/daughter. Please check one of the appropriate boxes:

_____ I have medical insurance coverage: ***Company: _____

_____ I do not have insurance and will assume all responsibility for payment of expenses incurred in the event of injury.

SECTION III: 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, cheer, football, track and field, volleyball, soccer, wrestling. (Please cross out any sport in which the student should not participate.)

Date: _____ (valid for 365 days unless rescinded.) Physician Signature: _____

SECTION IV: 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 Ellicott High School athletics, except those sports crossed out below:

baseball, basketball, cheer, cross country, football, track and field, volleyball, soccer, wrestling.

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. 22, 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 Ellicott Athletic Handbook and understand the policies.



CHSAA BYLAWS - PARENT & STUDENT INFORMATION

Checklist for Student Eligibility

If a student cannot check any of the items, he/she needs to contact the athletic director or principal.

- At least 5 full credit classes.
- (Choose 1) Option A (Failing no more than one class)
- Option B (Passing a minimum of 5 full-credit classes)
- Option C (Approved alternate academic program)
- Complied with first two items last semester.
- Physical exam within the last calendar year.
- Parent permit form on file at the school.
- Have not changed schools during the current school year without a corresponding move by parents.
- Will not or have not turned 19 before August 1.
- Has not been in high school longer than 8 consecutive semesters.
- Will not play more than 4 seasons in any sport.
- Will not compete or practice in any non-school events in my sport once reporting out for the team, without the permission of my principal.
- Has complied with all other school, district, and local eligibility requirements.

I have read and understand the CHSAA Eligibility Rules as documented here as well as specifically read in the CHSAA Bylaws. I understand and acknowledge the inherent risks of participating in Athletics and by signing this acknowledgement, I affirm my responsibility to prevent and report hazing. I also understand that any violation of this could result in school or team consequences that could include dismissal from the activity or further disciplinary consequences and/or referral to law enforcement.

Signed: _____ (Parent)

_____ (Participant)

_____ (School)

_____ (Date)

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____

Date of birth: _____

PHYSICIAN REMINDERS

1. 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?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> • Pupils equal • Hearing 		
Lymph nodes		
Heart* <ul style="list-style-type: none"> • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis 		
Neurological		
MUSCULOSKELETAL	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 <ul style="list-style-type: none"> • Double-leg squat test, single-leg squat test, and box drop or step drop test 		

*Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

**PREPARTICIPATION PHYSICAL EVALUATION
MEDICAL ELIGIBILITY FORM**

Name: _____ Date of birth: _____

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

- Medically eligible for certain sports

- Not medically eligible pending further evaluation

- Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
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

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

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 illness?		
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?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
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 years (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), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. 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?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

COVID-19

- A current physical MUST be on file. CHSAA recommends this PPE form.
 - COVID-19 specific questions should be included in the physical screening to include:
 1. Have you tested positive for COVID-19?
 2. Have you had any known exposure to a COVID-19 positive individual?
 3. Have you been tested for COVID-19?
 4. Have you had any new onset of cough or shortness of breath?
 5. Have you experienced any recent temperature greater than 100.3°
 - The most recent medical evidence recommends consideration of cardiac testing if a student athlete has previously tested positive for COVID-19. This should be discussed with the team physician on a case-by-case basis.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

Ellicott High School—Emergency Information Card

Player's Name _____ Sport _____

Date of Birth _____ Age _____ Grade _____

Parent's or Guardian's Name _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____

Emergency number if not at home or work _____

Chronic Ailments _____

Allergies _____

Physician _____ Phone _____

Hospital Preference _____

Insurance _____ Policy Number _____

CONSENT FOR EMERGENCY TREATMENT FOR INTERSCHOLASTIC ACTIVITY INJURIES: I, (we), parent(s) or guardian(s) of the student named above in consideration of my son's/daughter's opportunity to participate in interscholastic activities, hereby consent to emergency medical treatment, 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. I hereby waive on behalf of myself, my spouse (if applicable) and the above named student any liability of School District 22, its agents or employees arising out of such medical treatment.

(Signature of Parent/Guardian) Date _____