

**OFFICE USE ONLY**

ASB \_\_\_\_\_ Grade Check \_\_\_\_\_ Clearance Date \_\_\_\_\_ Trans. St. \_\_\_\_\_

**Castle Rock School District Athletic Card**  
This Section to be Completed by Student/Parent/Guardian

**Confidential**

Circle School attending: C.R. Middle School C.R. High School Student ID No. \_\_\_\_\_

Instruction: **Please print** all information except signatures.

Name \_\_\_\_\_ Parent/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Phone \_\_\_\_\_ Bus. Phone: Father \_\_\_\_\_ Mother \_\_\_\_\_

Grade \_\_\_\_\_ Birth date \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Two persons we may call in the event your parents cannot be reached:

\_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules or regulations of the school or state association.

Sports in which I plan to participate: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**WARNING**

Participation in any athletics activity will likely involve injury of some type to either yourself or a fellow student athlete. Such injury can include direct physical and possible crippling injury to one's body and the possibility of emotional injury experienced as a result of witnessing or actually inflicting injury to another. The severity of such injury can range from minor cuts, scrapes or muscle strains to catastrophic injury, such as complete paralysis or even death. Such injury can impair one's general physical and mental health and hinder one's future ability to earn a living, to engage in other business, social and recreational activities, and generally to enjoy life.

**ATHLETIC INSURANCE INFORMATION**

This Section to be Completed by Parent/Guardian

All school athletes must be covered by medical insurance provided by parent/guardian for the duration of the athletic activity(ies) in which they participate. Inform the school immediately should there be a change in insurance coverage.

Parent/Guardian, please initial at least one of the following to indicate current coverage:

\_\_\_\_\_ 1. Medical insurance with \_\_\_\_\_

(name of insurance company)

\_\_\_\_\_ 2. Student insurance plan (to be purchased by parent/guardian prior to participating in activity).

\_\_\_\_\_ Name of Family Physician

\_\_\_\_\_ Address

\_\_\_\_\_ Phone

**PARENTS OR GUARDIAN'S PERMISSION**

This Section to Be Completed by Parent/Guardian

Do you give permission to this student to take a physical examination from a school selected physician? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you give your permission for a physician to administer treatment to your child and to inform school officials of the nature of the injury? Yes \_\_\_\_\_ No \_\_\_\_\_

It is the parent's/guardian's responsibility to notify the school any time a medical problem occurs that would affect the health of the student as he/she participates in athletics.

I have read and completed all the sections of this card and all statements are true to the best of my knowledge. I hereby give my consent for the above student to engage in school association approved athletic activities as a representative of his/her school. I also give my consent for this student to accompany the team when it travels to other schools.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**STUDENT MEDICAL HISTORY**  
(This section is to be completed by parent/guardian)

Circle One

**GENERAL**

General

- |  |     |    |
|--|-----|----|
| 1. Have you ever been hospitalized?  | Yes | No |
| 2. Have you ever had surgery?  | Yes | No |
| 3. Are you presently taking any medication or pills?                               | Yes | No |
| 4. Do you have any skin problems (itching, rashes, acne)?                          | Yes | No |
| 5. Have you any other medical problems (infectious mononucleosis, diabetes, etc.)? | Yes | No |
| 6. Have you had a medical problem or injury since your last evaluation?            | Yes | No |
| 7. When was your last tetanus shot? _____  | Yes | No |
| 8. When was your last measles (MMR) immunization? _____                            |     |    |
- Explain "Yes" answers: \_\_\_\_\_

**HEART – LUNG**

Heart / Lung

- |  |     |    |
|--|-----|----|
| 1. Have you ever passed out during or after exercise?                                | Yes | No |
| 2. Have you ever been dizzy during or after exercise?                                | Yes | No |
| 3. Have you ever had chest pain during or after exercise?                            | Yes | No |
| 4. Do you tire more quickly than your friends during exercise?                       | Yes | No |
| 5. Have you ever had high blood pressure   | Yes | No |
| 6. Have you ever been told you have a heart murmur?                                  | Yes | No |
| 7. Have you ever had racing of your heart or skipped heartbeats?                     | Yes | No |
| 8. Has anyone in your family died of heart problems or a sudden death before age 50? | Yes | No |
| 9. Have you ever had heat or muscle cramps?  | Yes | No |
| 10. Have you ever been dizzy or passed out in the heat?                              | Yes | No |
| 11. Do you have any allergies (medicine, bees, or other stinging insects)?           | Yes | No |
| 12. Do you have trouble breathing or do you cough during or after activity?          | Yes | No |
- Explain "Yes" answers: \_\_\_\_\_

**EARS, NOSE, AND THROAT**

Ear/ Nose/ Throat

- |   |     |    |
|---|-----|----|
| 1. Have you ever had any problems with your eyes or vision? | Yes | No |
| 2. Do you wear glasses, contacts, or protective eye wear?   | Yes | No |
| 3. Do you have a known hearing loss?                        | Yes | No |
- Explain "Yes" answers: \_\_\_\_\_

**REFLEXES – MUSCULO-SKELETAL**

Reflexes/ Skeletal

- |   |     |    |
|---|-----|----|
| 1. Have you ever had a head injury?   | Yes | No |
| 2. Have you ever been knocked out or unconscious?   | Yes | No |
| 3. Have you ever had a seizure?   | Yes | No |
| 4. Have you ever had a stinger, bumer, or pinched nerve?  | Yes | No |
| 5. Have you ever sprained/strained, dislocated, fractured, broken, or had repeated swelling or other injuries of any bones or joints? | Yes | No |
- |                                    |                                   |                                |                                  |
|------------------------------------|-----------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> Head      | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Thigh | <input type="checkbox"/> Neck    |
| <input type="checkbox"/> Elbow     | <input type="checkbox"/> Knee     | <input type="checkbox"/> Chest | <input type="checkbox"/> Forearm |
| <input type="checkbox"/> Shin/Calf | <input type="checkbox"/> Back     | <input type="checkbox"/> Wrist | <input type="checkbox"/> Ankle   |
| <input type="checkbox"/> Hip       | <input type="checkbox"/> Hand     | <input type="checkbox"/> Foot  |                                  |
- Explain "Yes" answers: \_\_\_\_\_

**ABDOMEN**

Abdomen

- |   |     |    |
|---|-----|----|
| 1. Have you ever had abdominal surgery or problems?         | Yes | No |
| 2. Have you ever had hepatitis or mononucleosis infections? | Yes | No |
- Explain: \_\_\_\_\_

**REPRODUCTIVE** (Questions for Females only)

Reproduction/  
Hernia

- |  |
|--|
| 1. When was your first menstrual period? _____                     |
| 2. When was your last menstrual period? _____                      |
| 3. What was the longest time between your periods last year? _____ |
- Explain: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of student

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

**OFFICE USE ONLY**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Urinalysis \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Resting Pulse Rate \_\_\_\_\_

**MEDICAL OFFICE USE ONLY**

I certify that I have, on this date, examined the above student and recommend him/her as being physically able to participate in supervised activities except as indicated below:

Limitations and restrictions: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Examining Physician