DOUGLAS COUNTY SCHOOL DISTRICT RE-1
PHYSICIAN PERMIT AND MEDICAL INFORMATION FOR
ATHLETIC PARTICIPATION

Student's Name: _____ Birth Date: _____ Gender: M F

Year in School: 9th 10th 11th 12th Sport(s)_____

- Allergies: (include medication, food, latex, or other allergies):

- Medications (List ALL you are currently taking, including birth control pills):

Date of last Tetanus shot:_____ Any body piercing other than ears_____

List any surgeries you have had and the approximate date(s)._____

_____

****Please answer the following questions carefully and as accurately as possible. If you answer yes to any questions, please provide the date of occurrence and the care that was received.****

Concussion History: It is extremely important that this be accurate.

- How many and when?_____
- Did you lose consciousness? Yes_____ No_____Did you require care by a doctor? Yes_____No_____
- Have you ever been told by a doctor that you could not participate in a practice or game following a concussion? Yes_____ No_____.

	Yes	No
Have you ever been dizzy during or after exercise?		
Have you ever had chest pain during or after exercise?		
Do you tire more quickly than your friends during exercise?		
Has anyone in your family died of heart problems before 50?		
Do you have any skin problems (itching, rashes, acne)?		
Have you ever had heat or muscle cramps?		
Have you ever had a stinger, burner or pinched nerve?		
Have you ever been dizzy or passed out in the heat?		
Do you have any special equipment (braces, mouth or eye guards)?		

Have you ever had an injury or a fracture to any of the following:

	Yes	No	When/Treatment
Head/Neck			
Spine			
Shoulder(s)			
Elbow			
Wrist			
Hand			
Hip			
Knee			
Ankle			
Foot			

Have you ever had any of the following:

	Yes	No	When/Treatment
Diabetes			
If yes are you insulin dependent?			
Bladder or kidney infections			
Mono			
Hepatitis			Type:

Irritable bowel, colitis, Crohn's			
Collapsed lung			
Asthma			
If yes, do you use an:	(circle)		Nebulizer Inhaler
Chronic cough			
Trouble breathing			
Heart murmur			
High Blood pressure			
Racing or skipped heart beats			
Ear infections			
Eye infections			
Glasses/Contacts			
If yes to contacts	(circle)		Hard lenses Soft lenses
Hearing impairment			
Thyroid or adrenal disorder			
Blood or clotting disorder			
Anemia			
Seizure or epilepsy			
Dizziness			
Recurrent headaches			
Migraines			

Females Only:

Date of first menstrual period:_____

Do you ever miss your period:_____

Please print your name:_____

Signature:_____ Date:_____

PHYSICIAN PERMIT FOR ATHLETIC PARTICIPATION

I hereby certify that I have examined _____ and that the student was found physically fit to engage in school baseball, basketball, cheerleading, cross country, field hockey, football, golf, gymnastics, ice hockey, lacrosse, pom squad, soccer, softball, swimming, tennis, track and field, wrestling, volleyball.

(Please cross out any sport in which the student should not participate).

Student's Birthday:_____

Date of Physical:_____ Signed:_____

(Valid for 365 days unless rescinded) Physician (must be signed by MD, DO, NP, PAC, or DC)

PLEASE PRINT

PHYSICIAN'S NAME: _____

ADDRESS: _____

_____

PHONE NUMBER _____