DOUGLAS COUNTY SCHOOL DISTRICT RE-1

INTERSCHOLASTIC PARTICIPANT FORM

SCHOOL: ______________________________ GRADE: __________

NAME: ______________________________ BIRTH DATE: ____________ AGE: _____ SEX: _____

ADDRESS: ______________________________ CITY/ZIP: ______________________________

PARENT/GUARDIAN'S NAME: ______________________________ HOME PHONE: ______________

FATHER'S DAYTIME PHONE: ______________ MOTHER'S DAYTIME PHONE: ______________

IN AN EMERGENCY, IF PARENTS CANNOT BE REACHED, NOTIFY:

NAME: ______________________________ PHONE: ______________

FAMILY PHYSICIAN: ______________________________ PHONE: ______________

PARENT'S PREFERRED HOSPITAL: ______________________________ PHONE: ______________

FAMILY DENTIST: ______________________________ PHONE: ______________

INSURANCE CARRIER: POLICY:

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 football, golf, gymnastics, 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(Valid for 365 days unless rescinded) Physician (Must be signed by MD, DO, NP, PAC or DC)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: ______________

STATEMENT OF UNDERSTANDING

Registration Fee

The Board of Education has set the registration fee for HIGH SCHOOL athletics at $185.00 per sport per athlete. The fee for SEVENTH & EIGHTH grade athletics will be $85.00 per sport, with the exception of 8th Grade Football, which will have a fee of $115.00 per athlete.

Condition for Fee Refund

1. Refunds will be made to athletes who are cut by their coach.
2. If an athlete moves from the school's attendance area or from the District, the fee will be refunded on a prorated basis.
3. Athletes who quit the sport, become academically ineligible or are suspended from participation for disciplinary reasons are not eligible for a refund.

General

The interscholastic programs within the Douglas County School District Re.1 are offered to supplement the goals and objectives of public high school education.

In order to make contribution to the function and purpose of the total educational process, interscholastic activities must have as primary objectives the teaching of wholesome attitudes and disciplines. The programs must teach an appreciation for physical fitness, personal health, loyalty, personal sacrifice, dedication and teamwork.

In order to realize the potential of interscholastic programs, there are physical and mental disciplines which must be practiced.

Academics

Eligibility for competition in interscholastic activities is determined in accordance with the rules and regulations of the Colorado High School Activities Association, The Continental League and the Douglas County School District Re. 1.

X ______________________________ ______________

Signature of Parent or Guardian Date

DCSD Athletic/Activity Medical Information

Student's Name: ___________________________________ **Birth Date**: ____________ **Sex**: **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: _____________________

▪ List any body piercing you have other than on your 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 question, please provide the date of occurrence and the care that was received

Concussion History: It is <u>extremely</u> important that this be honest and 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____

Have you ever been advised by a doctor to wear protective head gear during sports? ______________________

Do you wear any type of protective head gear during sports? ____

	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)?	☐	☐

Please answer the following:

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

	YES	NO	
1. Head/neck	☐	☐	When/Treatment_________________________________
2. Spine	☐	☐	When/Treatment_________________________________
3. Shoulder(s)	☐	☐	When/Treatment_________________________________
4. Elbow	☐	☐	When/Treatment_________________________________
5. Wrist	☐	☐	When/Treatment_________________________________
6. Hand	☐	☐	When/Treatment_________________________________
7. Hip	☐	☐	When/Treatment_________________________________
8. Knee	☐	☐	When/Treatment_________________________________
9. Ankle	☐	☐	When/Treatment_________________________________
10. Foot	☐	☐	When/Treatment_________________________________

Have you ever had any of the following:

	YES	NO	
1. Diabetes	☐	☐	When/Treatment_______________________________
▪ If yes, are you insulin dependent:	☐	☐	When/Treatment_______________________________
2. Bladder or kidney infections	☐	☐	When/Treatment_______________________________
3. Mono	☐	☐	When/Treatment_______________________________
4. Hepatitis	☐	☐	When/Treatment______________________Type____
5. Irritable bowel, colitis, or Crohn disease	☐	☐	When/Treatment_______________________________
6. Collapsed lung	☐	☐	When/Treatment_______________________________
7. Asthma	☐	☐	When/Treatment_______________________________
▪ If yes, do you use an inhaler/nebulizer	☐	☐	(circle)
8. Chronic cough	☐	☐	When/Treatment_______________________________
9. Trouble Breathing or Coughing during exercise	☐	☐	When/Treatment_______________________________
10. Heart murmur	☐	☐	When/Treatment_______________________________
11. High blood pressure	☐	☐	When/Treatment_______________________________
12. Racing or skipped heart beats	☐	☐	When/Treatment_______________________________
13. Ear infections	☐	☐	When/Treatment_______________________________
14. Eye infections	☐	☐	When/Treatment_______________________________
15. Glasses/contacts	☐	☐	When/Treatment_______________________________
▪ If yes to contacts, Do you wear hard or soft lenses? **Hard Soft (circle)**	☐	☐	When/Treatment_______________________________
16. Hearing impairment	☐	☐	When/Treatment_______________________________
17. Thyroid or adrenal disorder	☐	☐	When/Treatment_______________________________
18. Blood or clotting disorder	☐	☐	When/Treatment_______________________________
19. Anemia	☐	☐	When/Treatment_______________________________
20. Seizure or epilepsy	☐	☐	When/Treatment_______________________________
21. Dizziness	☐	☐	When/Treatment_______________________________
22. Recurrent headaches	☐	☐	When/Treatment_______________________________
23. Migraines	☐	☐	When/Treatment_______________________________

Females Only:

Date of first menstrual period: ____

Do you ever miss your periods: ____

Please print your name: ____

Signature: ______________________________________Date:___________________