

DENVER
LUTHERAN
High School

NURTURING ACADEMIC EXCELLENCE
ENCOURAGING GROWTH IN CHRIST

Athlete's Name (Print) _____ Grade _____

DENVER LUTHERAN HIGH SCHOOL
2010/2011 Athletic Permission Form

Parent(s) Name (Print) _____

Home Address _____ City _____

Insurance: My son/daughter is adequately covered with medical insurance by a home/work/school insurance plan.

Parent _____ Date _____

Emergency Medical Authorization: Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above named athlete. In the event of serious illness, the need for major surgery or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given. In the event that an emergency arises during a practice or game session the coach, athletic trainer, and/or team physician may apply the necessary first aid treatment to the athlete immediately until the proper authorities can be reached. Consent is hereby given to administer prescription medication to the above designated athlete when the prescription is properly labeled and is accompanied by a written request by the professional person who prescribed the medication as well as by the parents.

Parent _____ Date _____

Transportation Policy: I will have on file at DLHS the Parental Permission Form regarding student transportation. I also agree that in the case of a motor vehicle owned by me, such a vehicle will be adequately insured and that such insurance becomes the primary carrier in the event of a claim that may result if the vehicle is used in a school-related activity.

Parent _____ Date _____

Emergency Contact Information: I will have on file at DLHS a current emergency contact information form which gives important emergency information to the appropriate personnel.

Parent _____ Date _____

DLHS Athlete/Parent Handbook: We have read and are in support of the mission statement of DLHS and the rules/expectations stated in the handbook including the warning of potential injury, training rules, eligibility rules and sportsmanship guidelines.

Parent _____ Date _____

Athlete _____ Date _____

TO BE COMPLETED BY PHYSICIAN'S OFFICE

Name _____ Age _____ Date Of Birth ____/____/____

L I M I T E D	Normal	Abnormal Findings					Initials
		1	2	3	4	5	
Height _____	Weight _____	BP _____	/		Pulse _____		
Vision R 20/ _____	L 20/ _____	Corrected: Y N	Pupils _____				
Cardiopulmonary							
Pulses							
Heart							
Lungs							
Tanner stage							
Skin							
Abdominal							
Genitalia							
Musculoskeletal							
Neck							
Shoulder							
Elbow							
Wrist							
Hand							
Back							
Knee							
Ankle							
Foot							
Other							

CLEARANCE

- A. Cleared _____
- B. Cleared after completing evaluation/rehabilitation for: _____
- C. Not cleared for: Collision Contact Non-contact Strenuous Moderately strenuous Non strenuous

Name Of Physician/P.A./Nurse Practitioner/Certified/Registered Chiropractor: _____

ADDRESS _____ PHONE _____

SIGNATURE OF MD/DO, PA, NA, DC-SPC# _____

DATE ____/____/____

TO BE COMPLETED BY STUDENT AND/OR PARENT

Date _____ Personal Physician _____ Sex _____ Age _____ Date of birth ____/____/____

1. Have you ever been hospitalized? Yes No
Have you ever had surgery? Yes No
2. Are you presently taking any medications or pills? Yes No
3. Do you have any allergies (medicine, bees or other stinging insects)? Yes No
4. Have you ever passed out during or after exercise? Yes No
Have you ever been dizzy during or after exercise? Yes No
Have you ever had chest pain during or after exercise? Yes No
Do you tire more quickly than your friends during exercise? Yes No
Have you ever had high blood pressure? Yes No
Have you ever been told that you have a heart murmur? Yes No
Have you ever had racing of your heart or skipped heartbeats? Yes No
Has anyone in your family died of heart problems or a sudden death before age 50? Yes No
5. Do you have any skin problems (itching, rashes, and acne)? Yes No
6. Have you ever had a head injury? Yes No
Have you ever been knocked out or unconscious? Yes No
Have you ever had a seizure? Yes No
Have you ever had a stinger, burner or pinched nerve? Yes No
Have you ever had heat or muscle cramps? Yes No
Have you ever been dizzy or passed out in the heat? Yes No
8. Do you have trouble breathing or do you cough during or after activity? Yes No
9. Do you use any special equipment (pads, braces, mouth/eye guard, etc.)? Yes No
10. Have you had any problems with your eyes or vision? Yes No
Do you wear glasses or contacts or protective eye wear? Yes No
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated or other injuries of any bones or joints? Yes No
 Head Shoulder Thigh Neck Elbow Knee Chest
 Forearm Shin/calf Back Wrist Ankle Hip Hand Foot
12. Have you had any other medical problems (mononucleosis, diabetes, etc.)? Yes No
13. Have you had a medical problem or injury since your last evaluation? Yes No
14. When was your last tetanus shot? _____
15. When was your last measles immunization? _____
When was your first menstrual period? _____
When was your last menstrual period? _____
What was the longest time between your periods last year? _____

Explain "yes" answers: _____

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

Date ____/____/____

Signature of athlete _____

Signature of parent/guardian _____