

CONSENT FOR EMERGENCY MEDICAL TREATMENT

Colorado law stipulates that no emergency room in the state can give treatment to a minor (other than in life-threatening situations) without the consent of a parent or guardian. To assure that your student receives the care he/she deserves when you're not there, complete this form, and return to the coach of the sport he/she is playing. In case of emergency, I hereby authorize any emergency medical and surgical care, treatment, and diagnostic tests deemed necessary in the emergency treatment of:

Student Name		Date of Birth		
Student Grade	Sport(s)		Date	
Parents'/Guardians' Names (please print)				
Parents/Guardians Signature				
Address, City, State, Zip Code				
Home Phone	Dad – Work	Mom – Work	Dad – Cell	Mom – Cell
Email Address @				
Doctor's Name and Phone Number				
Health Insurance Company	Group Number	Group Name		
Insured's Name	Insured's Social Security Number			
List Allergies to medications and other allergies the student has:				
List any special medical problems:				
List medications the student is currently taking:				
Date of last tetanus shot (month/year)				

Parents' initials

- _____ I have read, understand, and agree to follow and maintain the parent code of conduct that JICHS has put forth to promote a fun and safe athletic experience.
- _____ I, the parent or legal guardian of my student, give my permission for said student to be transported to athletic games or school activities. I understand that the driver of the vehicle has provided insurance information to the JICHS administrator and such information is on file in the administration and/or athletic office.
- _____ I have read the policy regarding getting back late and picking up students after games/practices and understand the consequences of not complying with the policy standard.
- _____ I hereby give my consent for my child to participate in supervised activities in the weight room.
- _____ I acknowledge that I have read and understood the rules, codes, and expectations as set forth in the James Irwin Charter High School Sports Handbook. I agree to abide by the rules, codes, and expectations in the Handbook. I understand that membership on any school team does not guarantee playing time.

Student's initials

- _____ I acknowledge that I have read the JICHS Student Athlete Code of Conduct. I agree to abide by the rules and spirit of this code in my affairs. I agree to represent myself, school, family, and community in the most positive manner possible at all times. I agree to encourage others to share these ideals.
- _____ I have read the policy regarding getting back late and picking up students after games/practices and understand the consequences of not complying with the policy standard.
- _____ I have read and understand the warnings for participation in supervised activities in the weight room.
- _____ I acknowledge that I have read and understood the rules, codes, and expectations as set forth in the James Irwin Charter High School Sports Handbook. I agree to abide by the rules, codes, and expectations in the Handbook. I understand that membership on any school team does not guarantee playing time.



PHYSICAL EXAMINATION AND PARENT PERMIT FOR ATHLETIC PARTICIPATION - PART I

I hereby certify that I have examined _____ and that the student was found physically fit to engage in high school sports (except as listed on back).

Student's birth date _____ Exp. Date (good for 365 days) _____

PARENT OR GUARDIAN PERMIT

WARNING: Although participation in supervised interscholastic athletics and activities may be one of the least hazardous in which any student will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC INJURY.** Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate this risk.

PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR OWN EQUIPMENT DAILY.

By signing this Permission Form, we acknowledge that we have read and understood this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.** By signing this form it allows my students medical information to be shared with appropriate medical staff when necessary in compliance with HIPPA (Health Insurance Portability and Accountability Act) Regulations.

I hereby give my consent for _____ to compete in athletics for _____ High School in Colorado High School Activities Association approved sports, except as listed on back, and I have read and understand the general guidelines for eligibility as outlined in the *Competitor's Brochure*.

Parent or Guardian Signature _____ Date _____

I have read, understand and agree to the General Eligibility Guidelines as outlined in the *Competitor's Brochure*.

Student Signature _____ Date _____

No student shall represent their school in interschool athletics until there is on file with the superintendent or principal a statement signed by his parent or legal guardian and a signed physical certifying that he/she has passed an adequate physical examination within the past year, that in the opinion of the examining physician, physician's assistant, nurse practitioner or a certified/registered chiropractor, he/she is physically fit to participate in high school athletics; and that he/she has the consent of his/her parents or legal guardian to participate.

NOTE: It is strongly recommended by the Colorado Department of Health that individuals participating in athletic events have current tetanus boosters. Tetanus boosters are recommended every 10 years throughout life. Boosters are recommended at the time of injury if more than five years have elapsed since the last booster.

If significant intervening illnesses and/or injuries have occurred, a more complete physical examination should be conducted. The physical examination form must be signed by a practicing physician, physician assistant, or nurse practitioner.

If a student athlete has been injured in practice and/or competition, the nature of which required medical attention, the student athlete should not be permitted to return to practice and/or competition until he/she has received a release from a practicing physician.

NOTE: The CHSAA urges an adequate physical examination be given when a student athlete changes levels of competition, i.e. Little League to Middle School, Middle School to High School.

PHYSICIAN SIGNATURE REQUIRED ON BACK

PART II -- MEDICAL HISTORY

This form must be completed and signed, prior to the physical examination, for review by examining physician. Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.

MEDICAL HISTORY OF STUDENT & FAMILY			YES	NO	MEDICAL HISTORY OF STUDENT & FAMILY			YES	NO
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		<input type="checkbox"/>	<input type="checkbox"/>	32.	Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Do you have an ongoing medical condition (like diabetes or asthma)?		<input type="checkbox"/>	<input type="checkbox"/>	33.	Have you ever had herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Are you currently taking any prescription or non prescription (over the counter) medicines or pills?		<input type="checkbox"/>	<input type="checkbox"/>	34.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Do you have allergies to medicines, pollens, foods or stinging insects?		<input type="checkbox"/>	<input type="checkbox"/>	35.	Date of last head injury or concussion: _____			
5.	Do you have prescriptions for use of epinephrine, adrenalin, inhaler, or other allergy medications?		<input type="checkbox"/>	<input type="checkbox"/>	36.	Have you ever been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Have you ever passed out or nearly passed out during or after exercise?		<input type="checkbox"/>	<input type="checkbox"/>	37.	Have you ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Have you ever passed out or nearly passed out at any other time?		<input type="checkbox"/>	<input type="checkbox"/>	38.	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Have you ever had discomfort, pain, or pressure in your chest during exercise?		<input type="checkbox"/>	<input type="checkbox"/>	39.	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
9.	Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath?		<input type="checkbox"/>	<input type="checkbox"/>	40.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>	
10.	Does your heart race or skip beats during exercise?		<input type="checkbox"/>	<input type="checkbox"/>	41.	Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>	
11.	Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection				42.	When exercising in heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>	
12.	Has a doctor ever ordered a test for your heart?		<input type="checkbox"/>	<input type="checkbox"/>	43.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	
13.	Has anyone in your family died suddenly for no apparent reason?		<input type="checkbox"/>	<input type="checkbox"/>	44.	Have you had any other blood disorders or amenia?	<input type="checkbox"/>	<input type="checkbox"/>	
14.	Does anyone in your family have a heart problem?		<input type="checkbox"/>	<input type="checkbox"/>	45.	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	
15.	Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death.)		<input type="checkbox"/>	<input type="checkbox"/>	46.	Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
16.	Does anyone in your family have Marfan syndrome?		<input type="checkbox"/>	<input type="checkbox"/>	47.	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>	
17.	Have you ever spent the night in a hospital?		<input type="checkbox"/>	<input type="checkbox"/>	48.	Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>	
18.	Have you ever had surgery?		<input type="checkbox"/>	<input type="checkbox"/>	49.	Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	
19.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?		<input type="checkbox"/>	<input type="checkbox"/>	50.	Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>	
20.	Have you had any broken or fractured bones or dislocated joints?		<input type="checkbox"/>	<input type="checkbox"/>	51.	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>	
21.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?		<input type="checkbox"/>	<input type="checkbox"/>	52.	Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	
22.	Have you ever had a stress fracture?		<input type="checkbox"/>	<input type="checkbox"/>	53.	What is the date of your last Tetanus immunization? Date: _____			
23.	Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?		<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY				
24.	Do you regularly use a brace or assistive device?		<input type="checkbox"/>	<input type="checkbox"/>	54.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>	
25.	Have you ever been diagnosed with asthma or other allergic disorders?		<input type="checkbox"/>	<input type="checkbox"/>	55.	Age when you had your first menstrual period?			
26.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		<input type="checkbox"/>	<input type="checkbox"/>	56.	How many periods have you had in the last 12 months? _____			
27.	Is there anyone in your family who has asthma?		<input type="checkbox"/>	<input type="checkbox"/>	57.	Do you take a calcium supplement?	<input type="checkbox"/>	<input type="checkbox"/>	
28.	Have you ever used an inhaler or taken asthma medicine?		<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here:				
29.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		<input type="checkbox"/>	<input type="checkbox"/>					
30.	Have you had infectious mononucleosis (mono) within the last three months?		<input type="checkbox"/>	<input type="checkbox"/>					
31.	Have you ever had mono or any illness lasting more than two weeks?		<input type="checkbox"/>	<input type="checkbox"/>					

Parent/Guardian Signature: _____

Athlete's Signature: _____

PART III -- PHYSICAL EXAMINATION

NAME: _____ SCHOOL: _____

HEIGHT: _____ WEIGHT: _____ SEX: _____ AGE: _____ DOB: _____

*Tanner Stage or Maturation Index? (males only): _____ BP: _____

*Percent Body Fat: _____ Pulse: *(rest) _____

*Audiogram _____ *(Exercise) _____

* Vision: Corrected: (L) _____ (R) _____ (Both) _____ *(Recovery) _____

Uncorrected (L) _____ (R) _____ (Both) _____ *FEV or Peak _____

Flow (rest) _____ *(Exercise) _____

*(Recovery) _____

	N	Abnormal		N	Abnormal
Eyes			Cervical Spine/neck		
Ears			Back		
Nose			Shoulders		
Throat			Arm/elbow/wrist/hand		
Teeth			Knees/hips		
Skin			Ankle/feet		
Lymphatic			Marfan Screen		
Lungs			*Urine		
Heart			*Hemoglobin or HCT and or Iron stores		
Peripheral pulses			^ Echocardiogram		
Abdomen			^ Neuropsych Testing		
Genitalia/hernia (male only)			^ Pelvic Examination		

***WHEN MEDICALLY INDICATED**

(Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)

^WITH SPECIAL INDICATIONS

(These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decision.)

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

- CLEARED WITHOUT RESTRICTIONS**
- Cleared **AFTER** further evaluation or treatment for: _____
- Cleared for **Limited participation** (check and explain "reason" for all that apply):
 Not cleared for (specific sports): _____
 Cleared only for (specific sports): _____
Reason(s): _____
- NOT CLEARED FOR PARTICIPATION:**
Reason(s): _____
- Other Recommendations: _____
 Recommend monitoring during early conditioning because of weight/fitness/other
 Recommend restrictions or monitoring of weight loss or gain
 Other: Reasons: _____

MD/DO, PA, NP, DE-SPC#, Signature: _____

Date of Examination: _____ Date Signed: _____

NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR and degree: (print):

Address: _____

City _____ State _____ Zip _____

2011-2012

JICS Parent/Guardian Volunteer Opportunities

We are very aware that the success of your child(ren) comes from the parental support you give them. We look forward to working with you to continue to develop your son's and/or daughter's full potential. We have many different opportunities for parents and guardians to be involved within our athletic programs. Would you please indicate if you would be willing to assist in any of the volunteer opportunities listed below?

_____ Collecting money at games

_____ Working concessions

_____ Working the clock or scorebook

_____ Keep statistics for teams

_____ Being a team mom (includes helping with team banquet)

_____ Being a line judge for volleyball

_____ Other _____

Name: _____

James Irwin Charter High School
5525 Astrozon Blvd
Colorado Springs, CO 80916
(719)302-9024

VOLUNTEER DRIVER INFORMATION (Optional)
**ALL VOLUNTEER DRIVERS MUST HAVE A COPY OF
THEIR DRIVERS LICENSE AND A COPY OF THEIR
PROOF OF INSURANCE FORM ON FILE.**

Drivers Name

Drivers License #:

Vehicle 1: Year, Make, Model, # of seatbelts

Vehicle 2: Year, Make, Model, # of seatbelts

Insurance Information:

Company

Agent

Phone #

Policy Expiration Date

Liability Limits (Dollar amount)

As a volunteer driver for James Irwin Charter High School (JICHHS), I certify that the above information is true and correct. I certify that my vehicle insurance is current and that my vehicle is in safe working condition. I will require all riders in my vehicle to wear a seat belt at all times. I will obey all traffic laws when acting as a volunteer driver for JICHHS. If I should be involved in any kind of traffic accident while transporting JICHHS students, I will immediately report the accident to JICHHS administration office or its designee. If any of the above information changes, I will provide updated information to the JICHHS administration office before continuing volunteer driving duties.

Driver 1

Date

Driver 2

Date