

**COLORADO INSTITUTE OF SPORTS MEDICINE –  
PHYSICAL THERAPY (CISM PT) & D11 SCHOOL DISTRICT**



**WHO:**

The **Colorado Institute of Sports Medicine (CISM PT)**, along with local volunteer physicians, are happy to announce that as part of their continued support of District 11 athletics - they will be holding a fundraising event for middle and high school student's athletic participation annual sports physicals!

**WHAT:**

CISM PT will be providing ANNUAL SPORTS PHYSICALS for middle and high school athletes.

The cost is **\$10 per athlete**, and **100%** of the proceeds will be donated back to the school's athletic department!

**WHEN:**

This event will be held **Tuesday, July 28th starting at 4 PM and line cut off at 7 PM sharp**. The event will take place on a **FIRST COME, FIRST SERVE BASIS** and will go until 8pm. After this time, no further athletes will be able to be seen- so we recommend getting there early!

**WHERE:**

**Colorado Institute of Sports Medicine- Central Clinic:**

1625 Medical Center Point, Ste. 180 Colorado Springs, CO 80907

**IMPORTANT:**

**Athlete Parents (if student is under 18):** Please complete the medical history form that we have provided for your athlete's upcoming physical. Forms can be turned in at check-in or filled out upon arrival.

NOTE- you will not be able to get into line for a physical until the form has been completed and payment has been made.

**QUESTIONS & CONTACT INFO:**

If you have questions about the process in which the physicals will be taking place- please reach out to your school's athletic director.

~ or ~

Email the event coordinator with CISM PT [kaitlin.cismrehab@gmail.com](mailto:kaitlin.cismrehab@gmail.com).



**PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)**

*This medical history form should be retained by the healthcare provider and/or parent and not turned into the school.*

*This form is valid for 365 calendar days from the date signed below.*

**1**

Revised 6/25

**MEDICAL HISTORY FORM**

**Student Information** (to be completed by student and parent) *print legibly*

Student's Full Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
 School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
 Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_  
 Family Healthcare Provider: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

List past and current medical conditions:

Have you ever had surgery? If yes, please list all surgical procedures and dates:

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

**Patient Health Questionnaire version 4 (PHQ-4)**

*Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)*

	Not at all	Several days	Over half of the days	Nearly everyday
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

**Mental Health Immediate Resources:** Colorado Crisis <https://coloradocrisisservices.org/> Call/text 988 or live chat at [988Colorado.com](https://988Colorado.com).  
 For additional Mental Health Resources, Please go to <https://chsaa.com/sports/2021/7/22/smac.aspx>

GENERAL QUESTIONS		Yes	No	HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.				<i>(continued)</i>			
1	Do you have any concerns that you would like to discuss with your provider?			8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
2	Has a provider ever denied or restricted your participation in sports for any reason?			9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
3	Do you have any ongoing medical issues or recent illnesses?			10	Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No
4	Have you ever passed out or nearly passed out during or after exercise?			11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash)		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			12	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
7	Has a doctor ever told you that you have any heart problems?						



PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

This medical history form should be retained by the healthcare provider and/or parent and not turned into the school.

This form is valid for 365 calendar days from the date signed below.

Revised 6/25

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ School: \_\_\_\_\_

Table with columns for BONE AND JOINT QUESTIONS, MEDICAL QUESTIONS, and MEDICAL QUESTIONS (continued). Includes questions 14-25 and a section for explaining 'Yes' answers.

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. No pupil shall participate in formal practice or represent his/her/their school in interscholastic athletics until this form is completed in its entirety and page 4 is on file with the principal or athletic director signed by his/her/their parents or legal guardian and a practitioner licensed in the United States to perform sports physicals certifying that:

Student-Athlete Name: \_\_\_\_\_(printed) Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Parent/Guardian Name: \_\_\_\_\_(printed) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Parent/Guardian Name: \_\_\_\_\_(printed) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)

This medical history form should be retained by the healthcare provider and/or parent and not turned into the school.

This form is valid for 365 calendar days from the date signed below.

Revised 6/25

PHYSICAL EXAMINATION FORM

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ School: \_\_\_\_\_

PHYSICIAN REMINDERS:

Consider additional questions on more sensitive issues.

Table with 2 columns and 4 rows of medical history questions.

Verify completion of Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. (check box if complete)

EXAMINATION

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

BP: \_\_\_/\_\_\_ ( \_\_\_/\_\_\_ ) Pulse: \_\_\_\_\_ Vision: R 20/ \_\_\_ L 20/ \_\_\_ Corrected: Yes No

Table for Medical assessment with columns for Normal and Abnormal Findings.

MUSCULOSKELETAL - healthcare professional shall initial each assessment

Table for Musculoskeletal assessment with columns for Normal and Abnormal Findings.

Name of Healthcare Professional (print or type): \_\_\_\_\_ Date of Exam: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_



PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT ONLY THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) print legibly

Student's Full Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_
School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_
Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_
Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_
Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_
Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_
Family Healthcare Provider: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

- Medically eligible for all sports without restriction
Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: (use additional sheet, if necessary)
Medically eligible for only certain sports as listed below:
Not medically eligible for any sports

Recommendations: (use additional sheet, if necessary)

I hereby certify that I have examined the above-named student-athlete using the CHSAA Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): \_\_\_\_\_ Date of Exam: \_\_\_/\_\_\_/\_\_\_
Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_
Signature of Healthcare Professional: \_\_\_\_\_ Credentials: \_\_\_\_\_ License #: \_\_\_\_\_

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

List any medical history that is relevant to participation in competitive sports. (explain below, use additional sheet, if necessary)

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

- Allergies/Anaphylaxis
Asthma
Cardiac/Heart
Concussion
Diabetes
Heat Illness
Orthopedic
Surgical History
Sickle Cell Trait
Mental Health
N/A - No relevant medical information to disclose

Medications: (use additional sheet, if necessary)

List: \_\_\_\_\_
\_\_\_\_\_

\*\*Signature of Student: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

\*\*Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct.

This form is not considered valid unless all sections are complete & signed.

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