High School
Athletic Participation Form

School Year:_____

NOTE: Submit only ONE Athletic Participation Form per year / New Emergency Card required for each sport season.

Starting in the Fall of 2024, the Colorado High School Activites Association now requires all student-athletes to have a CHSAA "Medical Eligibility Form" (physical on CHSAA form) on file with the school before participation is allowed.

PERSONAL INFORMATION

Sport(s):_____
(High School Use Only)

Last Name (PLEASE PRINT) First Name Middle Initial Student ID Grade

Address City State Zip Date of Birth Gender

Parent/Guardian Name (PLEASE PRINT) Year Started 9th Grade (HS ONLY) School Attended Last Semester

Parent/Guardian Email Address Cell Number Home Number Work Number

INSURANCE RELEASE – SIGNATURE REQUIRED – Line #1 or Line #2

Colorado Springs School District 11 Athletic & Activity Insurance Waiver

This statement release Colorado Springs School District 11 schools of responsibility in case of accident to my son/daughter while he/she is participating in interscholastic activities. I fully understand that Colorado Springs School District 11 does not provide accident and health insurance coverage for my son/daughter while he/she is participating in interscholastic activities. However, such insurance is made available by Colorado Springs School District 11 through an authorized agent. I further understand that it is my responsibility to provide accident insurance for my son/daughter.

1. I feel that my present insurance coverage is adequate:

Parent/Guardian Signature Date

*** OR ***

2. I am purchasing student accident insurance for my son/daughter through the authorized agent approved by the Board Of Education of Colorado Springs District 11:

Parent/Guardian Signature Date

PHOTO RELEASE – SIGNATURE REQUIRED – if permission granted.

I hereby give my permission to Colorado Springs School District 11 to publish photographs and/or videos of my student. I understand that such publication may occur through school and/or district newsletters, media releases, public reports, training material, assemblies, public meetings, the district websites, as well as through other school related publications and events. I further understand that this permission for Colorado Springs School District 11 to publish will remain in force until such a time the District Communications Office or School Principal is notified by me in writing of its withdrawal.

Parent/Guardian Signature Date

FEE SCALE and REQUIREMENTS

****** The full fee will be collected until proof of free or reduced lunch is submitted. ******

The parent/guardian is responsible to provide proof of the student's qualification for "Free" or "Reduced" lunch program. A copy of the current school years National School Lunch Program approval letter from CSSD11 Food Service must be brought to the school's business office at the same time of the sports registration. Call 719-520-2924 if you need a copy of your letter. A current letter must be submitted each year. ***The school's business office does not have access to this confidential information.***

Full Fee	$41.00	(Exceptions: Golf - $50.00, Ice Hockey - $100.00, Lacrosse - $100.00)
Reduced Fee	$28.00	(Exceptions: Golf - $50.00, Ice Hockey - $67.00, Lacrosse - $67.00)
Free Fee	$14.00	(Exceptions: Golf - $17.00, Ice Hockey - $33.00, Lacrosse - $33.00)
Non-District Student	$125.00	(Exceptions: Golf - $75.00, Ice Hockey - $150.00, Lacrosse - $150.00)
Family Max	$125.00	(within the same school – excludes Golf, Ice Hockey, Lacrosse)
3rd Sport Same Year	$21.00 / $14.00 / $7.00	
2nd Sport **SAME SEASON**	(Check with business office for fee amount. Fee will be determined by which sports competing in.)	

STATEMENT OF ELIGIBILITY AND ASSUMED RISKS GUIDELINES – SIGNATURES REQUIRED

WARNING: Although participation in supervised interscholastic athletics and activities may be one of the least hazardous which a student will engage in or out of schoolboy its nature, participation in the interscholastic athletics includes a risk of injury which may range in severity from minor to long-lasting catastrophic and may contract an infectious disease/virus. Although serious injuries are not common in supervised school programs, it is impossible to eliminate risk. Participants can and have the responsibility to help reduce the chance of injury as well as contracting infectious diseases/viruses. Players must obey all rules, report all physical problems to their coaches, follow a proper conditioning program, inspect their equipment daily, as well as staying at home when not feeling well. By signing this form, we acknowledge that we have read and understand this warning.

No student shall represent their school in interschool athletics until this statement is on file and signed by his/her parent/legal guardian and a physical form certifying that he/she has passed an adequate physical examination within one year, noting that in the opinion of the examining physician, physician's assistance, nurse practitioner, or certified/registered chiropractor, is physically fit to participate in high school athletics; that student has the consent of his/her parents or legal guardian to participate; and the parents and participant have received a Concussion Fact Sheet and have read, understand and agree to the *"The CSSD11 Athletic Handbook"* found at www.D11.org/athletics and CHSAA guidelines for eligibility found in *"The CHSAA Competitors Brochure"* found at www.chsaanow.com.

I hereby give my consent for the student mentioned on this form to compete in athletics for Colorado Springs School District 11, in Colorado High School Activities Association approved sports except those crossed out below. baseball, basketball, cross country, football, golf, gymnastics, ice hockey, lacrosse, soccer, softball, spirit/cheer/dance, swimming & diving, tennis, track & field, volleyball, wrestling. In consideration of my son's/daughter's opportunity to participate in interscholastic activities, hereby consent to emergency treatment, hospitalization or medical treatment as may be necessary for the welfare of the above named child, by a physician, qualified nurse, and/or hospital, in the event of injury or illness during all periods of time in which the student is away from his/her ;ega; residence as a member of an interscholastic activity team or group, and hereby waive on behalf of myself and the above named child and liability of Colorado Springs School District 11, any of its agents or employees, arising out of such medical treatment.

PARENT OR GUARDIAN AND STUDENT WHO DO NOT WISH TO ACCEPT THE RISK DESCRIBED IN THE WARNING ABOVE; ELIGIBLITY GUIDELINES; INSURANCE OR PHOTO RELEASE AND PAYMENT AGREEMENT SHOULD NOT SIGN THIS FORM.

_____

Parent/Guardian Signature Date

_____

Student Signature Date

FOR OFFICE USE ONLY – High School Use Only

F/L Letter? _____

Obligation CK	Fall Sports Fee	Sport	Type Payment	Date
Obligation CK	Winter Sports Fee	Sport	Type Payment	Date
Obligation CK	Spring Sports Fee	Sport	Type Payment	Date

PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

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Revised 4/24

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

	GENERAL QUESTIONS Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.	Yes	No
1	Do you have any concerns that you would like to discuss with your provider?		
2	Has a provider ever denied or restricted your participation in sports for any reason?		
3	Do you have any ongoing medical issues or recent illnesses?		
	HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4	Have you ever passed out or nearly passed out during or after exercise?		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7	Has a doctor ever told you that you have any heart problems?		

	HEART HEALTH QUESTIONS ABOUT YOU *(continued)*	**Yes**	**No**
8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10	Have you ever had a seizure?		
	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
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)		
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), Bragada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

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Revised 4/24

Student's Full Name: _____ Date of Birth: ___/___/_____ School: _____

BONE AND JOINT QUESTIONS		Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		

MEDICAL QUESTIONS		Yes	No
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?		
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
22	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
23	Have you ever become ill while exercising in the heat?		
24	Do you or does someone in your family have sickle cell trait or disease?		
25	Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS *(continued)*		Yes	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that you gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

Explain "Yes" answers here:

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. CHSAA bylaw 1780.1 states, "No pupil shall participate in formal practice or represent his/her/their school in interscholastic athletics until there is a statement 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: (a) he/she/they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in high school athletics; and (c) that he/she/they has the consent of his/her/their parents or legal guardian to participate. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

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: (a) he/she/they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in high school athletics. The CHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____ *(printed)* Student-Athlete Signature: _____ Date: ___/___/___

Parent/Guardian Name: _____ *(printed)* Parent/Guardian Signature: _____ Date: ___/___/___

Parent/Guardian Name: _____ *(printed)* Parent/Guardian Signature: _____ Date: ___/___/___

PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ___/___/_____ School: _____

PHYSICIAN REMINDERS:

Consider additional questions on more sensitive issues.

• Do you feel stressed out or under a lot of pressure?	• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	
• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?	

☐ 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

MEDICAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, Ears, Nose, and Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis		
Neurological		

MUSCULOSKELETAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and Arm		
Elbow and Forearm		
Wrist, Hand, and Fingers		
Hip and Thigh		
Knee		
Leg and Ankle		
Foot and Toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

Name of Healthcare Professional (print or type): _____ Date of Exam: ___/___/_____

Address: _____ Phone: (____) _____ E-mail: _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

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

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Revised 4/24

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

☐ Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp *(if required by school)*

Medications: *(use additional sheet, if necessary)*

List: _____

_____

Relevant medical history to be reviewed by athletic trainer/team physician: *(explain below, use additional sheet, if necessary)*

☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait ☐ Mental Health

Explain: _____

_____

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.

Emergency Information Card

Players Name _____Grade ___

Parent or Guardian Name _____

Address _____

Phone # _____

Players Name _____Grade ___

Parent or Guardian Name _____

Address _____

Phone # _____

Physician Name _____

Physician Phone # _____

Chronic Aliments _____

Consent for Emergency Treatment for Interscholastic Activity Injuries

I _____,

parent or guardian of _____
in consideration of their opportunity to participate in interscholastic activities, herby concent to emergency medical treatment, hospitalization or other medical treatment as may be necessary for the welfare of the above named child, by a physician, qualified nurse, and/or hospital, in the event of injury or illness during all periods of time in which the student is away from their legal residence as a member of an interscholastic activity team or group, and hereby waive on behalf of myself and the above named child any liability of the School District, any of its agents or employees, arising out of such medical treatment.

_____ _____

Dated Signature of Parent or Guardian