

In the event a parent will be providing transportation for away games/practices please fill out and return the following page ALONG with the required copy of your driver's license and insurance.



Heritage Christian Academy
2506 Zurich Drive . Fort Collins, Colorado . 80524
970-494-1022 fax 970-494-1025
website: HeritageChristian.info

HCA Volunteer Form 2016-17

Parent Drivers / Chaperones

For the concern and safety of all students, families and staff, please read and sign the following volunteer form before agreeing to be a Parent Driver and / or Chaperone for any HCA event or field trip.

If I am driving my own vehicle I will:

___ Bring my Proof of Vehicle Insurance, and drivers license to the school office for photo copying where it will be kept on file.

___ I will take only as many children in my vehicle as I have fully operating seatbelts.

(This copy will be kept on file in the office for the duration of the school year – please make sure you update if your insurance card expires)

1. As a volunteer driver / chaperone I will:

- Not make any unplanned stops while driving to or from the field trip or event destination, nor deviate from the planned itinerary.
- Stay with the group of drivers to ensure safety to the larger group.
- If applicable: I will share my cell phone number with other drivers for the purpose of communication due to an emergency.
- I will chaperone the students assigned to me by the classroom teacher or sponsoring teacher as directed per event or field trip.
- I will not text or unnecessarily use my cell phone while driving.

Name: _____ Phone: _____

(Please Print Full Name)

Signature: _____

**PARENT PERMIT FOR ATHLETIC PARTICIPATION IN
MIDDLE SCHOOL SPORTS**

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 Heritage Christian Academy

Parent/Guardian 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.

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 1/4 to 1/2 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) _____

	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			^Neuropsyc 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 restrictions or monitoring of weight loss or gain
 Recommend
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 _____