Laramie County School District #1
Cheyenne, WY
School Physical Examination

PAGE ONE - RETURN TO SCHOOL – SCHOOL USE ONLY

Student Name:		Sex:	Date of Birth:
School:	Grade:	Sport(s):	
Address:	City/State:	Primary Ph:	Secondary Ph:
Date of Exam:	Physician/Provider:		
In case of emergency, contact:			
Name(s):	Relationship:	Primary Ph:	Secondary Ph:

STUDENT/PARENT/GUARDIAN INFORMED CONSENT

Participation in all activities requires the acceptance of risk of possible serious injury. The risk can be minimized by following your coaches' rules and procedures, by familiarizing yourself with the rules of the activity, and by following the specific rules issued by manufacturers for the safe use of your activity equipment. The risk is always there, but you can help minimize it by making safety a shared responsibility. When you make the decision to participate in an activity, you are assuming the shared responsibility of following the activities rules, the coaches' rules, and the equipment manufacturer's rules. You, as a participant, can help make the activity safer by not intentionally using techniques which are illegal, and which can cause serious injury.

Your signature below indicates that you have been informed about the importance of following rules in activities participation; and you realize that there is a risk of being injured that is inherent in all activities. You realize that the risk of injury may be severe, including the risk of fractures, brain injuries, paralysis or even death.

Activity programs/sports specifically excluded: _____

Signature of Student _____ **Date** _____ **Signature of Parent** _____ **Date** _____

PARENT/GUARDIAN CONSENT FOR EMERGENCY MEDICAL ASSISTANCE

I hereby authorize LARAMIE COUNTY SCHOOL DISTRICT #1 and its faculty members in charge of my child named below to obtain all necessary medical care for my child in the event that I cannot be reached to authorize it myself. I hereby authorize any licensed physician and/or medical personnel to render necessary medical treatment to my child.

Student Name:	**Parent/Guardian Name(s):**
Address:	**Phone:**
Insurance Information	
Insurance Company:	**Policy #:**
Signature acknowledges I you have read and understand the statement and give consent for emergency assistance that may be necessary.	
Signature of Parent/Guardian	**Date:**

HEALTH CARE PHYSICIAN/PROVIDER USE ONLY

DATE OF EXAM _____

MARK ONE BOX: **[ ] Cleared**	**[ ] Conditionally Cleared***	**[ ] Not Cleared****
*Conditionally cleared after completing evaluation/rehabilitation:		
**Not cleared due to:		
Recommendation for student:		
Name of Provider (Print): Babson & Associates Primary Care		Date:
Title of Business: Babson & Assoc	Address: 1331 Prairie Ave Ste 1 Cheyenne, WY 82009	Phone: (307) 632-0728
Signature of Provider:		

PROVIDE A COPY OF THIS FORM TO APPROPRIATE LCSD #1 PERSONNEL PRIOR TO START OF SEASON

Rev. 04/2025

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PAGE TWO – COMPLETED BY STUDENT/PARENT/GUARDIAN PRIOR TO EXAM

	Questions	Yes	No		Questions	Yes	No
1	Have you had a medical illness or injury since your last check up or sports physical?			25	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position? (i.e. knee brace, neck brace, foot orthotics, dental retainer, hearing aid)		
2	Have you ever been hospitalized overnight?			26	Have you had any problems with your eyes or vision?		
3	Are you currently taking any prescription of nonprescription (over-the-counter) medications or pills or use an inhaler?			27	Do you wear glasses, contacts, or protective eyewear?		
4	Do you have any allergies? (i.e. pollen, medicine, food, insect bites or stings)			28	Have you ever had a sprain, strain, or swelling after injury?		
5	Have you ever passed out or been dizzy during or after exercise?			29	Have you broken or fractured any bones or dislocated any joints?		
6	Have you ever had chest pain during or after exercise?			30	Do you suffer from anxiety or stress?		
7	Do you get tired more quickly than your friends do during exercise?			31	Have you had any other problems with pain or swelling in muscles, tendons, bones, and/or joints?		
8	Have you ever had racing of your heart or skipped heartbeats?				*If yes, check the appropriate box and explain below*		
9	Have you had high blood pressure or high cholesterol?				[ ] Head [ ] Elbow [ ] Hip		
10	Have you ever been told you have a heart murmur?				[ ] Neck [ ] Forearm [ ] Thigh [ ] Back [ ] Wrist [ ] Knee		
11	Has any family member or relative died of heart problems or of sudden death before age 50?				[ ] Chest [ ] Hand [ ] Shin/calf		
12	Have you had a severe viral infection (i.e. myocarditis or mononucleosis) within the last month?				[ ] Shoulder [ ] Finger [ ] Ankle [ ] Upper Arm [ ] Foot		
13	Has a physician ever denied or restricted your participation in sports for any heart problems?			32	Do you want to weigh the weight you are now?		
14	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?			33	Do you lose weight regularly?		
15	Have you ever had a head injury or concussion?			34	Do you, or someone in your family, have sickle cell trait or disease?		
16	Have you ever been knocked out, become unconscious, or lost your memory?						
17	Have you ever had a seizure?				**FEMALES ONLY**		
18	Have you ever had numbness or tingling in your arms, hands, legs, feet?			35	When was your first menstrual period? (date _____)		
19	Have you ever had a stinger, burner, or pinched nerve?			36	When was your most recent menstrual period? (date_____)		
20	Have you ever become ill from exercising in the heat?			37	How much time do you usually have from the start of one period to the start of another? (days _____)		
21	Do you cough, wheeze, or have trouble breathing during or after activity?			38	How many periods have you had in the last year? (_____)		
22	Do you have asthma?			39	What was the longest time between periods in the last year? (____)		
23	Do you have seasonal allergies that require medical treatment?						
24	Do you have frequent or severe headaches?						

If YES to any of the above questions, share more information here:

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

Signature of Student Date _____ Signature of Parent/Guardian Date _____

FOR PHYSICIAN/PROVIDER PRIOR TO EXAM

DO NOT RETURN THIS PAGE TO SCHOOL DISTRICT PERSONNEL