



# Monument Academy: Required Athletic Forms







## PARENT PERMISSION & PHOTO RELEASE

Monument Academy

### **ASSUMPTION OF RISK STATEMENT:**

#### WARNING:

I/we are aware that participation in any sport can be a dangerous activity involving risk of injury. I/we understand that the dangers and risk of participation in any sport include, but are not limited to, death, serious neck or spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to bones, joints, ligaments, muscles, tendons, and other aspects of the muscular, skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being.

Because of the dangers of participating in any sport, I/we recognize the importance of following coaches' instructions regarding playing techniques, proper use of equipment, training and other team rules, and agree to obey such instructions. I/we understand that coaches may use their own judgment in securing medical aid and ambulance services in case of an emergency, or mild injuries where parents cannot be reached. Also, the coach or Athletic Director may apply first aid treatment until the parent and/or family physician can be contacted.

In consideration of permitting me to try out for Monument Academy Athletics and engage in all activities related to the team, including, but not limited to, trying out, practicing, or playing/participating in that sport, I/we hereby assume all risks associated with participation and agree to hold the Monument Academy, its' employees, agent, representative, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to Monument Academy Athletics. The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees, and all members of my family.

I/we have read the foregoing, acknowledging the "WARNING" above, accept the risks described and agree to abide by the principles and regulations contained therein.

X \_\_\_\_\_  
Student Signature Date

X \_\_\_\_\_  
Parent or Guardian Signature Date

### **PHOTOGRAPH RELEASE: (PLEASE CHECK ONE!)**

Often, parents will set up "team hosting sites" to post and share photos of athletes that are taken at athletic events. Occasionally, the Athletic Director would like to share a team photo on the Central Colorado Athletic League (CCAL) website when one of our teams wins a league championship. Photos that are posted on the CCAL website would be of the team as a whole, and would not include names. We require permission to take and post these photos, or a refusal of permission.

**Yes**, I give permission to release my student's photo for promotional purposes.

**No**, I do not MA give permission to use my student's photo.



**INSURANCE WAIVER / PHYSICIAN INFORMATION / PHYSICAL**

**Interscholastic Participation Form**

Monument Academy

**INTERSCHOLASTIC ACTIVITIES INSURANCE WAIVER:**

I/we fully understand Monument Academy does not provide accident, health, or life insurance coverage for the above named student while he/she is participating in activities associated with interscholastic sports.

I/we further understand that it is my/our responsibility to provide adequate insurance coverage to the above named student.

**X** \_\_\_\_\_  
Parent or Guardian Signature Date

**PHYSICIAN'S PERMIT FOR ATHLETIC PARTICIPATION, PART I**

I certify that I have examined \_\_\_\_\_ and that the student was found physically fit to engage in any interscholastic sport including but not limited to football, volleyball, cross country, basketball, track and field, cheerleading, and soccer. (Please cross out or list any sport in which the student should not participate.)

Student's Name: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_\_

Date of Physical: \_\_\_\_\_ (valid for one year)

Physician's Signature: \_\_\_\_\_  
(Must be signed by MD or DO)

PLEASE PRINT OR STAMP:  
Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I give my consent for medical treatment deemed necessary by physicians designated by the school authorities and/or for transportation to a hospital for treatment for any illness or injury resulting from his/her athletic participation.

I understand this authorization will only be enforced when I cannot be personally contacted.

**X** \_\_\_\_\_  
Parent or Guardian Signature Date



# Monument Academy

## 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				MEDICAL HISTORY OF STUDENT & FAMILY			
		YES	NO			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 anemia?	<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"/>	<b>FEMALES ONLY</b>			
				54.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
				55.	Age when you had your first menstrual period?		
24.	Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	56.	How many periods have you had in the last 12 months? _____		
25.	Have you ever been diagnosed with asthma or other allergic disorders?	<input type="checkbox"/>	<input type="checkbox"/>	57.	Do you take a calcium supplement?	<input type="checkbox"/>	<input type="checkbox"/>
26.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Explain "Yes" answers here:</b>			
27.	Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>				
28.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>				
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"/>				



Monument Academy

**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			^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 \_\_\_\_\_



## **STUDENT-ATHLETE HANDBOOK: LETTER OF AGREEMENT**

Monument Academy

The Monument Academy Student-Athlete Handbook contains policies, procedures, expectations, information regarding schedules and communication, and information about specific sports/activities. All student-athletes, and parents of student-athletes must read, and agree to abide by the policies and expectations outlined in the handbook in order for student-athletes to participate in the Monument Academy Athletics Program.

You may pick up a copy of the Monument Academy Student-Athlete Handbook from the front office. A link to the Monument Academy Student-Athlete Handbook can be found on the Monument Academy website at <http://www.monumentacademy.net/secondary-school/athletics/>

We have read, understand, and are committed to abide by the policies and procedures as outlined in the Monument Academy Student-Athlete Handbook. Any violation of these policies and procedures may result in revocation of participation privileges.

### **Student-Athlete Signature :**

Student-Athlete Name (please print): \_\_\_\_\_

Student-Athlete Signature: \_\_\_\_\_ Grade: \_\_\_\_\_ Date: \_\_\_\_\_

### **Parent Signature:** (at least one signature is required)

Parent Name (please print): \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Name (please print): \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**VOLUNTEER DRIVER, CONSENT TO RIDESHARE  
AUTHORIZATION & CONTACT INFORMATION RELEASE**

Monument Academy

**VOLUNTEER DRIVER STATUS/AUTHORIZATION: (PLEASE CHECK ONE!)**

**Yes**, I volunteer to transport athletes other than my own child to school sponsored athletic events in a private (non-school owned) car. **\*\* YOU MUST** also fill out the *Driver Authorization Form* required by Monument Academy, and the *Release Of Individual Driver Records Form* required by the State of Colorado. **YOU MUST** attach current, valid copies of your Driver's License and automobile insurance cards to the Driver Authorization Form. All of these steps must be completed in order for you to be permitted to transport athletes to school sponsored athletic events.

**No**, I do not volunteer to transport athletes other than my own child to athletic events in a private (non-school owned) car, or I will only transport my own child. You need not fill out the Driver Authorization Form, or the Permission For Release Of Individual Records Form.

**CONSENT TO RIDESHARE: (PLEASE CHECK ONE!)**

**Yes**, I give my child permission to ride to school sponsored athletic events with a school approved driver in a private (non-school owned) car.

**No**, I do not grant permission for my child to ride to school sponsored athletic events with a school approved driver in a private (non-school owned) car. I will always transport my child to school sponsored athletic events.

**CONTACT INFORMATION RELEASE: (PLEASE CHECK ONE!)** (For use in arranging carpool transportation to school sponsored athletic events)

**Yes**, I give permission to release my contact information to Monument Academy coaches, and other Monument Academy families involved in carpool **ONLY!**

**No**, I do not grant permission to release my contact information to anyone.

**X** \_\_\_\_\_  
Parent or Guardian Signature Date





## DRIVER AUTHORIZATION FORM

### Authorization to Use Privately Owned Vehicle for School Athletic Events

Monument Academy

Driver Name: \_\_\_\_\_

#### **CERTIFICATION:**

In accordance with school policy, approval is requested to use a privately owned automobile on official school business.

A. I certify that whenever I drive a privately owned vehicle on school business, the vehicle will always be:

1. Covered by liability insurance for the minimum amount prescribed by the school: \$300,000 single limit or \$100,000 per person/\$300,000 per accident, bodily injury and \$50,000 Property Damage.
2. Equipped with one seat belt or child restraint system for every passenger.
3. To the best of my knowledge, in safe mechanical condition and adequate for passenger transportation and/or work to be performed.

B. I further certify that while using a privately owned vehicle on official school business, all motor vehicle laws will be obeyed, including all passengers' use of seat belts and the appropriate child restraint systems. Any traffic accidents, no matter how minor, will be reported immediately to the Director of Human Resources at 719- 481-1950 ext. 1252.

C. I understand that as a volunteer driver, I am not covered by Monument Academy or the School District 38 automobile insurance.

D. I further certify that I am at least 21 years old, and that I possess a valid Colorado driver license:

E. I authorize Monument Academy to obtain a copy of my MVR from the State of Colorado.

X \_\_\_\_\_

Parent or Guardian Signature

Date

**\*\* PLEASE ATTACH (STAPLE) A COPY OF YOUR DRIVER'S LICENSE & INSURANCE CARD BELOW. THIS FORM IS NOT ACCEPTABLE WITHOUT THE ATTACHED DOCUMENTS \*\***

**\*\* PLEASE ATTACH DOCUMENTS \*\***



Monument Academy

# RELEASE OF INDIVIDUAL DRIVER RECORDS FORM

Please complete the form by FILLING IN THE SHADED BOXES,  
SIGNING AND DATING



DR 2559 (02/10/17)  
COLORADO DEPARTMENT OF REVENUE  
Division Of Motor Vehicles  
Driver Control Section, Room 164  
PO Box 173345  
Denver, CO 80217-3345  
www.colorado.gov/revenue

Search Fee	<input type="checkbox"/>
Certified fee	<input type="checkbox"/>

## Permission to Release Driver Records to Self or Another Person

Driver's License offices provide only personal driving record information.  
Records and/or other requests are available only at 1881 Pierce St., Lakewood, CO  
Pursuant to §42-1-206(1)(b)(II) (7)(a) and (7)(b)(XIII), C.R.S.

I (Please Print Last Name)		First Name	
<i>hereby authorize the release of personal information contained in records maintained by the Colorado Department of Revenue, Division of Motor Vehicles, to:</i>			
Last Name Buzzell		First Name Sherry	
		<input checked="" type="checkbox"/> Check if to self	
<i>Pursuant to the Driver's Privacy Protection Act (18 USC 2721) and Colorado law (§24-72-204, §42-1-206 (1)(b)(II)).</i>			
<b>Driver</b>			
Driver's Date of Birth		Driver's License Number	
Signature		Date	
Signature of Parent or Guardian if Driver is a Minor		Date	
<b>Person Receiving Record</b>			
Release Records to: Last Name Buzzell		First Name Sherry	
Driver's License Number		State	
Company (if applicable) Monument Academy Charter School			
Mailing Address 1150 Villge Ridge Point			
City Monument		State CO	Zip Code 80132
If your check is returned for insufficient funds or a closed account, you may not be issued or renew any type of driver's license or identification card until the original check is redeemed and an administrative and short check fee are paid.			
Under penalty of perjury, I attest that I shall not obtain, resell, transfer, or use the information in any manner prohibited by law. I understand that motor vehicle or driver records that are obtained, resold, or transferred for purposes prohibited by law may subject me to civil penalties under federal and state law. All of the information provided is true and accurate to the best of my knowledge.			
Signature of Requestor Sherry Buzzell			Date 5/22/17