ARAPAHOE HIGH SCHOOL – PHYSICAL EXAMINATION FORM
MARCHING BAND AND GUARD / WINTER GUARD / WINTER PERCUSSION

Mr. Shawn Funk – Director of Bands
Mr. Kenny Bailey – Color Guard Mr. Dustin Arndt – Percussion
2201 East Dry Creek Road
Centennial, Colorado 80122
Phone: (303) 347-6031 Fax: (303) 347-6065
www.arapahoeband.com

PARTICIPANT INFORMATION

Name: _____ **Gender:** M F **Grade:** 9 10 11 12

Address: _____ **Phone:** _____

City/Zip: _____

Parent/Legal Guardian: _____

Who do you live with? ___ Parent ___ Legal Guardian ___ Relative ___ Other (please specify) _____

PHYSICAL EXAMINATION INFORMATION

All participants are required to have a statement on file with the Director of Bands or Principal signed by a practicing physician certifying the participant has passed an adequate physical examination and is physically fit to participate in high school marching band, color guard, winter guard, and winter percussion. If significant intervening illness and/or injuries have occurred, a more complete examination should be conducted. If a participant has been injured in practice or competition, the nature of which required medical attention, then the participant will not be permitted to return to practice and/or competition until she/he has received a release from a practicing physician. **Participants will not be allowed to practice or participate until a physician's statement is on file in the Band Office.**

PHYSICAN PERMIT FOR PARTICIPATION
****PHYSICAL EXAMINATIONS ARE GOOD FOR ONE CALENDAR YEAR****

I hereby certify that I have examined _____ and that this student is found physically fit to engage in high school marching band and guard, winter guard, and winter percussion (except as listed).

Student's birth date: _____/_____/_____ **Date of examination:** _____/_____/_____

Clearance (please choose one)

A. Cleared
B. Cleared after completing evaluation/rehabilitation for _____
C. Not Cleared for ( ) Collision
( ) Contact
( ) Non-contact ___ Strenuous ___ Moderately Strenuous ___ Non-Strenuous

Recommendation: _____

Name of Physician/PA/Nurse Practitioner/Certified-Registered Chiropractor (PLEASE PRINT):

_____

Address: _____

Phone: _____

Signature of MD/DO, PA, NA, DC-SPC # _____