This form is required for ALL Middle School Students

Dear Parents,

Because our students spend a lot of time outdoors, on trips, and otherwise performing physical tasks, we require that all Middle School students have on file a current record of a physical exam. Physicals are good for 365 days. Students cannot join trips, field trips, nor athletics without having a current physical on file.

Please schedule an appointment with your child's physician and take this form with you. Make sure the Doctor signs the attached form and provides the date of the most recent exam.

If your child has had a physical within the past year, your doctor may simply need to complete this form.

The required verification can be faxed to our school at **720-710-9971**. If your physician is going to fax verification, please follow-up with us. It is ultimately your responsibility to get this information to us.

As always, if you have any questions, please contact me at **720-531-3311**.

Becca Schrank
Health Assistant, DCS Montessori Charter School
Email: Health@dcsmontessori.org

Note: Please don't wait on this – doctor offices are traditionally bombarded in August with such requests. Give them a bit of extra time and arrange to have this accomplished as soon as you can.

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PHYSICAN PERMIT FOR ATHLETIC / FIELD TRIP PARTICIPATION

This form is to be filled out by a licensed physician or other health care professional that has seen the child in the last twelve months.

Name of Facility: DCS Montessori Charter School Type of Facility: Public School
Address of School: 311 Castle Pines Parkway, Castle Pines, Colorado 80108
Telephone number: 720-531-3311 Fax number: 720-710-9971

Child's Name: _____ Gen_____ Date of Birth_____

I hereby certify that I have examined the above named student and that he/she was found physically fit to engage in the following:

- ☐ Basketball
- ☐ Cross Country
- ☐ General Field Trips
- ☐ Overnight Trips / Outdoor Education
- ☐ Soccer
- ☐ Ultimate Frisbee
- ☐ Volleyball

Date of physical: _____

Additional Comments: _____

_____

_____

_____ _____

Signature of licensed physician or other health care provider Date

Name of Physician: _____

Address: _____

_____

Phone Number: _____

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