

William S. Hart Union High School District

Athletic Clearance Form

1. Warning to Student-Athlete and Parents
2. Certificate of Student Insurance
3. Parent Consent and Co-Curricular Agreement

Active Sport(s):

Fall _____

Winter _____

Spring _____

You must complete all sections of this form before your daughter/son can participate in Interscholastic athletic practices and contests

Please print all information

Name _____ ID# _____ Grade 9 10 11 12

Address _____ City _____ Zip _____

Birth Date _____ Phone # _____

State _____

School Attended Last Year _____ Sex M F

Name of Doctor _____ Doctor Phone() _____ FAX() _____

Address _____ City _____ Zip _____

1. Warning to Student-Athlete and Parents :

By nature, competitive athletics may put students in a situation where **SERIOUS, CATASTROPHIC**, and perhaps, **FATAL ACCIDENTS** may occur. By granting permission for your student-athlete to participate in athletic competition, you, the parent or guardian, acknowledge that such risks exist.

Student-Athlete's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

2. Certificate of Student Insurance :

It is the responsibility of the parent/guardian to secure insurance coverage prior to participation in athletics. Sections 32220-32224 of the Education Code requires that each member of an athletic team have insurance. I certify that my student is covered by insurance as required and further, said coverage will be in force for the entire current school year. I understand that the school district has made available an accident insurance program in which my child may enroll and that the program is optional.

Name of Insurance Company _____ Policy # _____

Myers-Stevens Insurance (optional) Date mailed: _____

3. Parental Consent and Co-Curricular Agreement :

I hereby give consent for my student to participate in Interscholastic Athletics in the Wm. S. Hart Union High School District. In case of injury to my daughter/son, you are authorized to have her/him treated. I further understand that in case of injury, the school staff and Associated Student Body is relieved of all liability from medical or hospital bills sustained in participation in interscholastic athletic competition. I hereby give my consent for my daughter/son to compete in sports and go with a representative of the school on any trip(s). I have also read the co-curricular policy regarding requirements for participation in school activities and agree to abide by the rules and regulations. (See "Notice of Rights, Regulations and Responsibilities")

Student-Athlete's Signature _____ Date _____

Parent's/Guardian's Signature _____ Date _____

William S. Hart Union High School District

CERTIFICATE OF PHYSICAL EXAMINATION

Name _____ DOB _____ / _____ / _____

Height _____ Weight _____ Pulse _____ BP _____ / _____

Please place a “✓” as either Normal or Abnormal for all findings below. Please describe in detail all abnormal findings.

	Normal	Abnormal	Comments
Heart			
Pulses			
Lungs			
Neck			
Back			
Shoulder/Arm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle/Foot			
Other pertinent medical findings			

Additional comments: _____

List any restrictions and duration: _____

I hereby certify that _____ was examined by me on _____ 200_____

and found to be physically fit to engage in athletics.

Physician's Signature _____ **Date** _____

Stamp name or attach card of medical office here ▼

Pre-participation Physical Examination Valencia High School

Name _____
 Last First Middle Birthdate Sport
 Address _____
 Street City State Zip Phone
 Grade: Freshman Sophomore Junior Senior

MEDICAL HISTORY

Your responses will remain strictly confidential
 Have you ever had any problems with any of the following?

Head and Neck

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Concussions? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized for a concussion? |
| <input type="checkbox"/> | <input type="checkbox"/> | Ever had a neck or spine injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have problems with your eyes? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat illness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures, "fits, convulsions, or epilepsy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any impairment of hearing? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have numbness, tingling, or weakness in
Any extremity? |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with teeth, tonsils, or mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliance? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are they removable? |

Give and details to any "Yes" answer.

Urinary/Intestinal

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a kidney disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Passed blood in your urine? |
| <input type="checkbox"/> | <input type="checkbox"/> | Injury to the kidneys? |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning on urination? |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | Family history of diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | Mono? |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach or Intestinal disorders? |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation or diarrhea? |
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia? |
| <input type="checkbox"/> | <input type="checkbox"/> | (men only) Problems with testicles? |
| <input type="checkbox"/> | <input type="checkbox"/> | (women only) Problems with pain
or discharge from your breasts? |

Give and details to any "Yes" answer.

Cardiovascular-Respiratory

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart problems? <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur? |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pains? |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty breathing? |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma? (list medications) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Family history for heart attacks or strokes? <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you anemic (low blood count)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat exhaustion or heat stroke? |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic to medications, pollens, foods, insects or pets?
(circle one of the above) Which? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Passed out while working out? |

Give dates and details to any "Yes" answers

List what you are allergic to: _____

I have read and answered the above question to the best of my ability.

Student/Athlete Signature _____

Parent Signature _____

Reviewed by Physician _____

Musculoskeletal

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with shoulders R L |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with elbows R L |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with wrists R L |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with fingers R L |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with hips R L |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with knees R L |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with ankles R L |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with feet R L |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any pins, screws or
Metal in your body? |
| <input type="checkbox"/> | <input type="checkbox"/> | Had any broken bones? |
| <input type="checkbox"/> | <input type="checkbox"/> | Had any dislocated joints? |
| <input type="checkbox"/> | <input type="checkbox"/> | Get frequent muscle pull or strains? |
| <input type="checkbox"/> | <input type="checkbox"/> | Back Pain? |
| <input type="checkbox"/> | <input type="checkbox"/> | Shin splints? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any surgeries? |

Give dates and details to any "Yes" answers.

Date: _____