CAPISTRANO UNIFIED SCHOOL DISTRICT

Physical Clearance Form

SPORTS: *(Please check all that apply)*

- o Cross Country
- o Football
- o Girls Golf
- o Girls Tennis
- o Girls Volleyball
- o Boys Water Polo
- o Surfing
- o Basketball
- o Soccer
- o Girls Water Polo
- o Wrestling
- o Baseball
- o Softball
- o Boys Golf
- o Swimming
- o Boys Tennis
- o Track
- o Boys Volleyball
- o Lacrosse
- o Dance
- o Cheer

Name____________________ Grade in 2021-22_____ Male______ Female______ Date of Birth___/___/___

Address____________________ City & Zip Code____________________ Phone____________________

Father/Guardian____________________ Work phone____________________ Cell phone ____________________

Mother/Guardian____________________ Work phone____________________ Cell phone ____________________

Emergency Contact ____________________ Phone____________________ Insurance ____________________

***I hereby give my consent for the above named student (son/daughter/ward) to compete in sports and to go with a representative of the school on any trips. In case of injury,you are authorized to have him/her treated.

*SIGNATURE OF PARENT/GUARDIAN*______________________________ Date ____________________

HEALTH HISTORY: *TO BE COMPLETED BY PARENT BEFORE DOCTOR EXAM*

Any past or present:	Yes	No
Problems with vision	___	___
Eyeglasses	___	___
Contacts	___	___
Problems with hearing	___	___
Hearing aid.	___	___
Blacking out or fainting	___	___
Unconsciousness	___	___
Convulsions,	___	___
seizures	___	___
Heart problems	___	___
Rheumatic fever	___	___
Bleeding disorders	___	___
Blood sugar problems	___	___
Hypoglycemia	___	___
Diabetes	___	___
Allergies– type ____________		
Bee or insect stings	___	___
Hospitalizations	___	___

	Yes	No
Surgeries	___	___
Dental problems	___	___
Braces	___	
False teeth	___	___
Painful joints	___	___
Broken bones	___	___
Body part,date ____________		
Knee or ankle problems	___	___
Require support/brace	___	___
Need for medication	___	___
Name ____________		
Menstruation problems	___	___
Hernias	___	___
Asthma	___	___

OTHER HEALTH ASPECTS THE DOCTOR AND SCHOOL SHOULD BE AWARE OF:

____

____

	Yes	No
Any history of chest pain with exercise?	___	___
Any history of "racing" heart or skipped beats?	___	___
Do you experience passing out, near passing out or unexpected tiredness during exercise?	___	___
Any family history of sudden cardiac death in afamily member under the age of 50?	___	___
Any family history of Marfan's syndrome Or prolonged QT syndrome*	___	___
Any history of temporary numbness or paralysis of *both* arms and/or legs following head/spine trauma?	___	___
Any history of recent severe viral illness, infectious mononucleosis, or hepatitis?	___	___
Any history of the following: absence of one kidney?	___	___
males: absence of one testicle?	___	___
Any history of blindness in one eye?	___	___
Any current active skin infection?	___	___

PHYSICAL EXAM: DATE: _______________ HEIGHT_______________ WEIGHT _______________

PULSE: RESTING_______________ AFTER ACTIVITY_______________ B.P. _______________

EYES	___	THROAT	___	ABDOMEN	___	ORTHOPEDIC	___
EARS	___	LYMPH GLANDS	___	HERNIA	___	SKIN	___
TEETH	___	THYROID	___	POSTURE	___	OTHER	___
BRACES	___	HEART	___	MUSCLE TONE	___		
NOSE	___	LUNGS	___	REFLEXES	___		

Special doctor recommendations or restrictions ______________________________

I have examined the above student and do recommend that he/she is physically fit for full participation in sports.

(Must be signed by a PHYSICIAN, PHYSICIAN'S ASSISTANT or NURSE PRACTITIONER)

Name of physician____________________ M.D/DO/PA/NP Date__________

Physician's Office Stamp

Signature______________________________ Phone ____________________

CAPISTRANO UNIFIED SCHOOL DISTRICT
ATHLETIC INSURANCE VERIFICATION

Education Code Section 32221.5. Under state law, school districts are required to ensure that all members of school athletic teams have accidental bodily injury insurance providing at least $1500 of scheduled medical/hospital benefits. This insurance requirement can be met by the school district offering insurance or other health benefits that cover medical and hospital expenses. Some pupils may qualify to enroll in no-cost or low-cost local, state, or federally sponsored health insurance programs. Information about these programs may be obtained by calling: 1(800)281-9799.

If you have at least $1500, accidental bodily injury insurance, please fill out ITEM 1below **(medical card required).**
If you do not have accidentally bodily injury benefits for your son, daughter, or ward, please fill out ITEM 2 below.

ITEM 1 The athlete has accidental bodily injury insurance providing at least $1500 of scheduled medical hospital benefits.

ATHLETE'S NAME ______________ PARENT/GUARDIAN SIGNATURE ______________

ITEM 1 PROOF OF INSURANCE IS REQUIRED

****PLEASE ATTACH A PHOTOCOPY OF INSURANCE CARD HERE****

ITEM 2 The athlete does not have accidental bodily injury insurance required. YOU MUST COMPLETE APPROPRIATE MYERS-STEVENS & TOOHEY APPLICATION and mail directly to Myers-Stevens & Toohey & Co. Inc.

____
ATHLETE'S NAME

INTERSHOLASTIC
TACKLE FOOTBALL
9-12 GRADES
(SEE MYERS STEVENS WEBSITE (www.myers-stevens.com) FOR APPLICATION AND PRICING)

FULLTIME (2417) SCHOOL TIME
ACCIDENT PLAN
(BOTH PLANS COVER ALL INTERSCHOLASTIC SPORTS EXCEPT TACKLE FOOTBALL) DENTAL PLANS

(SEE MYERS STEVENS WEBSITE (www.myers-stevens.com) FOR APPLICATION AND PRICING)

We have subscribed to Myers-Stevens & Toohey & Co., Inc for athletic insurance, which meet the limits requested. (Myers-Stevens & Toohey & Co. Inc. will send verification of insurance to each school)

Parent/Guardian Signature ______________ Date ______________