CAPISTRANO UNIFIED SCHOOL DISTRICT

Physical Clearance Form

SPORTS: *(Please check all that apply)*

- ○ Cross Country
- ○ Football
- ○ Girls Golf
- 0 Cheer.Song
- ○ Girls Tennis
- ○ Girls Volleyball
- ○ Boys Water Polo
- 0 Girls Flag Football
- ○ Surfing
- ○ Basketball
- ○ Soccer
- ○ Girls Water Polo
- ○ Wrestling
- ○ Baseball
- ○ Softball
- ○ Boys Golf
- ○ Swimming
- ○ Boys Tennis
- ○ Track
- ○ Boys Volleyball
- ○ Lacrosse
- 0 Beach Volleyball

Name_____ Grade in 2026-27 _____ 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:

_____

_____

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: (Physician/Physician's asst/Nurse Practitioner) 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 _____

This physical plus an online clearance consitutes physical clearance