CAPISTRANO UNIFIED SCHOOL DISTRICT

Physical Clearance Form

Name_____ Grade in 2025-26 _____ 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 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_____

Student athletes will not be cleared to participate in sports until this physical AND the online account for the 2025-2026 school year has been completed on www.athleticclearance.com