

**CAPISTRANO UNIFIED SCHOOL DISTRICT**

**SPORTS:** *(Please check all that apply)*

**Physical Clearance Form**

- |                                        |                                           |                                     |                                           |                                    |                                          |                                   |
|----------------------------------------|-------------------------------------------|-------------------------------------|-------------------------------------------|------------------------------------|------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Cross Country | <input type="checkbox"/> Girls Tennis     | <input type="checkbox"/> Surfing    | <input type="checkbox"/> Girls Water Polo | <input type="checkbox"/> Softball  | <input type="checkbox"/> Boys Tennis     | <input type="checkbox"/> Lacrosse |
| <input type="checkbox"/> Football      | <input type="checkbox"/> Girls Volleyball | <input type="checkbox"/> Basketball | <input type="checkbox"/> Wrestling        | <input type="checkbox"/> Boys Golf | <input type="checkbox"/> Track           |                                   |
| <input type="checkbox"/> Girls Golf    | <input type="checkbox"/> Boys Water Polo  | <input type="checkbox"/> Soccer     | <input type="checkbox"/> Baseball         | <input type="checkbox"/> Swimming  | <input type="checkbox"/> Boys Volleyball |                                   |

Name \_\_\_\_\_ Grade in 2019-20 \_\_\_\_\_ 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**

<u>Any past or present:</u>	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Problems with vision	_____	_____	Surgeries	_____	_____
Eyeglasses	_____	_____	Dental problems	_____	_____
Contacts	_____	_____	Braces	_____	_____
Problems with hearing	_____	_____	False teeth	_____	_____
Hearing aid.	_____	_____	Painful joints	_____	_____
Blacking out or fainting	_____	_____	Broken bones	_____	_____
Unconsciousness	_____	_____	Body part, date _____	_____	_____
Convulsions,	_____	_____	Knee or ankle problems	_____	_____
seizures	_____	_____	Require support/brace	_____	_____
Heart problems	_____	_____	Need for medication	_____	_____
			Name _____		
Rheumatic fever	_____	_____	Menstruation problems	_____	_____
Bleeding disorders	_____	_____	Hernias	_____	_____
Blood sugar problems	_____	_____	Asthma	_____	_____
Hypoglycemia	_____	_____	<b>OTHER HEALTH ASPECTS THE DOCTOR</b>		
Diabetes	_____	_____	<b>AND SCHOOL SHOULD BE AWARE OF:</b>		
Allergies— type _____			_____		
Bee or insect stings	_____	_____	_____		
Hospitalizations	_____	_____	_____		
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 a family 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.** \_\_\_\_\_

<b>EYES</b>	_____	<b>THROAT</b>	_____	<b>ABDOMEN</b>	_____	<b>ORTHOPEDIC</b>	_____
<b>EARS</b>	_____	<b>LYMPH GLANDS</b>	_____	<b>HERNIA</b>	_____	<b>SKIN</b>	_____
<b>TEETH</b>	_____	<b>THYROID</b>	_____	<b>POSTURE</b>	_____	<b>OTHER</b>	_____
<b>BRACES</b>	_____	<b>HEART</b>	_____	<b>MUSCLE TONE</b>	_____		
<b>NOSE</b>	_____	<b>LUNGS</b>	_____	<b>REFLEXES</b>	_____		

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 \_\_\_\_\_

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

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

\_\_\_\_\_  
ATHLETE'S NAME

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

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**ITEM 1 PROOF OF INSURANCE IS REQUIRED**

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

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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](http://www.myers-stevens.com)) FOR APPLICATION AND PRICING)

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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](http://www.myers-stevens.com)) FOR APPLICATION AND PRICING)

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*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

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