★ SJHHS /CUSD ATHLETIC CLEARANCE FORM 2019-2020 ★

Fall Sports		Winter Sports		Spring Sports	
Cross Country ☐Boys ☐Girls	☐Tennis-Girls	Basketball ☐Boys ☐Girls		☐Baseball	☐Tennis-Boys
☐Football	☐Volleyball-Girls	Soccer ☐Boys ☐ Girls		☐Golf-Boys	Track ☐Boys ☐Girls
☐Golf-Girls	☐Water Polo-Boys	☐Water Polo-Girls		Lacrosse ☐Boys ☐Girls	☐Volleyball-Boys
☐Surf				Swim ☐Boys ☐Girls	

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.

REQUIRED - Parent/Guardian Signature: _____ 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: (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_____

Student athletes will not be cleared for participation/play until this paperwork is turned AND the online account for 2019 – 2020 is completed at: www.athleticclearance.com. The online account must be updated each school year.