Antelope Valley HS 661-948-8552	Eastside HS 661-946-3800	Highland HS 661-538-0304	Knight HS 661-533-9000	Lancaster HS 661-726-7649	Littlerock HS 661-944-5209	Palmdale HS 661-273-3181	Quartz Hill HS 661-718-3100

Antelope Valley Union High School District
Physician Certification / Parent Authorization / Insurance Requirement Form

STUDENT INFORMATION

Last Name	First Name	Initial	Grade	Date of Birth	Sex
Address		Phone Number			
Sport(s):		Student ID #:			

With whom are you living? (Circle One): Parents Legal Guardians Relative(s) Other:

School Attended Last Semester: City: State:

Are you a transfer student? (Circle One): Yes No | Total Semesters of High School Attendance:

PARENT AUTHORIZATION

I understand that the Antelope Valley Union High School District does NOT carry athletic injury insurance for athletes and is NOT responsible or liable for athletic injuries. In order to participate in the above named sport, all participants must be examined by a licensed physician and insured against athletic injuries.

1) INSURANCE: Check the following statements which apply.
   - □ My son/daughter (or ward) has student insurance. What sport? ____________________
   - □ My son/daughter (or ward) is covered for the above named sport under our FAMILY health/medical plan.
     Name of Company: ________________________ Policy #: ________________________
   - □ ***FOOTBALL ONLY***. My insurance policy covers tackle football. I understand that I can purchase SISC Tackle Football Coverage if my student is not already covered. **PARENT INITIAL**: _______
2) ATHLETIC PARTICIPATION, TRIP CONSENT, AND EMERGENCY CARE AUTHORIZATION:
   I hereby give my consent for the above named person to compete in the above named sport and to go with a representative of the school on any athletic trip related to the above sport. In case my son/daughter (or ward) is injured you are authorized to have him/her treated.
3) My student and I have completed the online clearance process through www.athleticclearance.com and I verify that the digital signatures entered on the site are from myself and my student.

Date: _______________ Name:________________________________ Signature:____

PREPARTICIPATION PHYSICAL EVALUATION (FOR OFFICE USE ONLY)

Height__________ Weight__________ % Body Fat (optional)__________ Pulse_____ BP ___ /___ (___ /___, ___ /___)

Vision R 20/_____ L20/_____ Corrected: Y N Pupils: Equal _______ Unequal _______

Area	Normal	Abnormal	Area	Normal	Abnormal	Area	Normal	Abnormal
Ears/Nose/Throat			Heart			Orthopedic		
Thyroid			Lungs			Posture		
Lymph Glands			Abdomen			Reflexes		
Skin			Hernia			Muscular		

Abnormal History/Findings: ____

Allergies: ____ Regular Medications: ____

Comments: ____

- □ CLEARED FOR ATHLETICS
- □ NOT CLEARED – REASON: ____

Name & Address of Physician/Medical Professional: ____

Physician Signature: ____ Date: ______________________

This form must be on file with the school of attendance for verification of eligibility prior to participation in any athletic event.