CAPISTRANO UNIFIED SCHOOL DISTRICT
2017-2018 ATHLETIC CLEARANCE PACKET

SPORTS: (fall)_____ **(winter)**_____ **(spring)** _____

Name_____**Grade in 2017-18**_____**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:		

	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: 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** _____

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

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

_____ _____
ATHLETE'S NAME PARENT/GUARDIAN SIGNATURE

ITEM 1 PROOF OF INSURANCE IS REQUIRED

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

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 BROCHURE FOR APPLICATION AND PRICING)

FULLTIME (2417) SCHOOL TIME
ACCIDENT PLAN
(BOTH PLANS COVER ALL INTERSCHOLASTIC SPORTS EXCEPT TACKLE FOOTBALL) DENTAL PLANS

(SEE MYERS STEVENS BROCHURE FOR APPLICATION AND PRICING)

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