CONEJO VALLEY UNIFIED SCHOOL DISTRICT
1400 E. Janss Road
Thousand Oaks, CA 91362

ATHLETIC CLEARANCE (Insurance Requirement/Parent Authorization/Physician Certification)

Student – Last Name First Name M.I.		Grade	Date of Birth		Gender
Street Address:	City:		State:	Zip:	
Parent(s) or Guardian(s) Name:			Home Phone:		
Street Address (if different than student):	City:		State:	Zip:	
Emergency Phone:	Father's Work Phone:		Mother's Work Phone:		
Father's e-mail address:	Mother's e-mail address:				
Family Physician's Name, Address, Telephone:					
School Attended Last Fall:	School Attended Last Spring:		Student Number:		

*****PLEASE PUT A CHECK MARK NEXT TO THE ACTIVITIES/SPORTS THIS AUTHORIZATION COVERS**

( ) Baseball ( ) Basketball ( ) Cheerleading ( ) Cross Country ( ) Dance ( ) Football
( ) Golf ( ) Lacrosse ( ) Marching Band ( ) Soccer ( ) Softball ( ) Swimming
( ) Tennis ( ) Track ( ) Volleyball ( ) Water Polo ( ) Wrestling

INSURANCE REQUIREMENT:
The Conejo Valley Unified School District, in accord with Education Code 32221, requires protection for medical and hospital expenses resulting from bodily injury for each member of an athletic team. The cost is to be paid by each participant. Minimum coverage requirement options as contained in the Education Code are shown below:

(a) A group or individual plan with accidental benefits of at least $200 for each occurrence and major medical coverage of at least $10,000, with no more than $100 deductible and not less than 80% payable for each occurrence. (Note: retired military covers only 75 %.)
(b) Group or individual medical plans which are certified by the Insurance Commissioner to be equivalent to the required coverage of at least $1500.
(c) At least $1500 for all such medical and hospital expenses.

Student insurance designed to assist compliance with the Education Code requirements is available; forms are in the school office. If you have applied for student insurance, please indicate so below. If the student has other health or accident insurance which meets the minimum requirements above, please list the company name and policy number below.

Insurance Company Name and Address:	
Insured's Name:	Policy and/or Group Number:

PLEASE NOTE: MANY INSURANCE POLICIES EXCLUDE TACKLE FOOTBALL. PLEASE CHECK YOUR POLICY CAREFULLY OR CONSULT YOUR INSURANCE CARRIER.

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I hereby grant permission for the above named student to play in the activity/interscholastic sports programs of ______________________ High School, and to go with a representative of the school on any related trips, and release school officials from any liability connected therewith. In case this student is injured, school officials are AUTHORIZED to grant permission for emergency treatment in my absence under the provisions of the Medicine Practice Act. It is understood that this authorization is given in advance of any specific diagnosis. Further, I agree to accept financial responsibility for such treatment rendered in my absence.

I hereby certify that the above-named student is covered by insurance that meets the minimum requirement of California law as outlined above. I agree to notify the school if any of the above coverage should change.

( ) Yes ( ) No I hereby grant permission for my son/daughter's telephone number and address to be released to the official Boosters Club for any activity/sport in which he/she participates.

________________________________ (Date) ________________________________ (Signature)

PHYSICIAN'S CLEARANCE

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities.

________________________________ Physician's Name (Stamp or Print)

________________________________ Physician's Signature and Date of Physical

________________________________ Physician's Address (Stamp or Print)

________________________________ Physician's Telephone Number

NOTE: History and Consent Must be Completed Prior to Physical Examination

Please return all copies of this form to the Athletic Department

STUDENT NAME:_____
(Last) (First) (M.I.)

GENDER: ( ) Male ( ) Female BIRTHDATE:_____

HEALTH HISTORY – TO BE COMPLETED BY PARENT/GUARDIAN

This section is to be carefully completed by the student and his/her parent(s) or legal guardians(s) before participation in activities/interscholastic sports in order to help detect possible risks.

MARK ONLY THOSE WHICH APPLY! Include date for conditions that are not current. Explain "Yes" answers below.

Allergy	☐ Yes	☐ No	False Teeth	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Glasses/Contacts	☐ Yes	☐ No	Mumps	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Concussion	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Sinus problems	☐ Yes	☐ No
Emotional problems	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Epilepsy/Seizure Disorder	☐ Yes	☐ No	Menstrual Cramps	☐ Yes	☐ No	Whooping Cough (Pertussis)	☐ Yes	☐ No
Frequent Fainting	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Other	☐ Yes	☐ No

Explain "Yes" here:_____

_____

_____

List all surgeries, fractures, sprains, or dislocations below:

Nature of problem	Year	Nature of problem	Year

Reasons and dates for any prolonged absence(s) from school:_____

_____

Substance(s) to which student is allergic:_____

_____

Dates of most recent: Tetanus Booster _____ Chest x-ray _____ Smallpox vaccination _____

Whooping Cough (Pertussis) vaccination_____

PHYSICAL EXAMINATION SUMMARY – TO BE COMPLETED BY PHYSICIAN

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Note any abnormalities:

Eyes (sclera, corneas):_____

Ears (canals, TMs):_____

Nose (septum, mucosa):_____

Throat (tonsils, teeth):_____

Cardiovascular (pulses, murmurs):_____

Respiratory:_____

Abdomen (organs, masses):_____

Genitalia (testes, hernia):_____

Musculoskeletal:_____

Neurological:_____

Strength and Coordination:_____