



CONEJO VALLEY UNIFIED SCHOOL DISTRICT

1400 E. Janss Road
Thousand Oaks, CA 91362

SPORTS/ACTIVITIES MEDICAL CLEARANCE FORM

Student Last Name	Student First Name		Student M.I.
School	Grade	Date of Birth	Gender
Parent/Guardian Name		Parent/Guardian Phone Number	

STATEMENT OF CONSENT/AUTHORIZATION TO TREAT/INSURANCE REQUIREMENT:

I hereby grant permission for the above named student to participate in the activities/interscholastic sports programs at the above named school as indicated on his/her athletic clearance documentation. I give permission for him/her to go with and be supervised by a representative of the school on any related trips, and I release school officials from any liability connected therewith. In case this student becomes ill or is injured, school officials are AUTHORIZED to grant permission for emergency treatment in my absence under the provisions of the Medicine Practice Act. This includes any x-ray, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered by or under the general or special supervision of a licensed physician or surgeon or the staff of an accredited hospital. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required. Further, I agree to accept financial responsibility for such treatment rendered in my absence.

I also certify that the above-named student is covered by insurance as required by CVUSD in accordance with California Education Code 32221* which requires protection for medical and hospital expenses resulting from bodily injury for each member of an athletic team and that it is each participant's responsibility to obtain and pay the cost of his/her own coverage. In the event that the student is not covered by private/group insurance, I understand that insurance coverage may be purchased through the school. ** Should the student lose coverage during the course of the school year, I agree to notify the school immediately.

This authorization shall remain in effect until the end of the school year unless sooner revoked in writing and delivered to the school.

Parent Signature

Date

*Information about Education Code 32221 and the minimum insurance requirements may be found on the school's website.

**Information about student insurance designed to assist in compliance with the Education Code requirements is available at the school.

PHYSICAL EXAMINATION SUMMARY (to be completed by physician):

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

Note any abnormalities:

Eyes (sclera, corneas): _____	Abdomen (organs, masses): _____
Ears (canals, TMs): _____	Genitalia (testes, hernia): _____
Nose (septum, mucosa): _____	Musculoskeletal: _____
Throat (tonsils, teeth): _____	Neurological: _____
Cardiovascular (pulse, murmurs): _____	Strength and Coordination: _____
Respiratory: _____	

Dr. Comments/Concerns: _____

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, 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

Physician's Address (Stamp or Print)

Date of Exam

Physician's Telephone Number (Stamp or Print)