

VISALIA UNIFIED SCHOOL DISTRICT
HIGH SCHOOL ATHLETIC CLEARANCE/DATA FORM

List the sports(s) in which you plan to participate: Fall _____
Winter _____
Spring _____

Student Name: _____ Date of Birth: _____ M F (Circle One)

School: (Circle One) EDHS GWHS MWHS RHS Grade: (Circle One) 9 10 11 12

Address: _____ Home Phone: _____ Work Phone: _____

Father's or Legal Guardian's Name: _____ Home Phone: _____ Work Phone: _____

Mother's or Legal Guardian's Name: _____ Home Phone: _____ Work Phone: _____

Other Person or Persons to contact if parents or guardian are not available:

Name: _____ Home Phone: _____ Work Phone: _____

Physician's Name _____ Phone: _____ Are you allergic to any medications? No / Yes

Name of medication(s) _____

(Please indicate any prescription drugs your child is currently taking.)

Are you a High School Transfer Student? No / Yes (Circle One)

ATHLETICS – RISK WARNING

SERIOUS, CATASTROPHIC AND PERHAPS FATAL INJURY MAY RESULT FROM ATHLETIC PARTICIPATION. By its very nature, competitive athletics may put students in situations in which SERIOUS, CATASTROPHIC and perhaps FATAL ACCIDENTS may occur. Students and parents must assess the risks involved in such participation and make their choice to participate in spite of those risks. No amount of instruction, precaution or supervision will totally eliminate all risk of injury. Just as driving involves choice of risk; athletic participation by students also may be inherently dangerous. The obligation of parents and students in making this choice to participate cannot be overstated. There have been accidents resulting in death, paralysis or serious permanent physical impairment as a result of athletic competition. By granting permission for your student to participate in athletic competition, you, as a **parent or guardian**, acknowledge that such a risk exists. By choosing to participate, you, **the student**, acknowledge that such a risk exists.

Sudden Cardiac Arrest (SCA) – I have received and reviewed the information about SCA. I understand that a student experiencing any warning signs of SCA will be removed from play and not allowed to return to the sport until cleared by a licensed physician.

Concussion/Head injury - I have received and reviewed the information about concussion and head injury. I understand that a student suspected of sustaining a concussion or head injury will be removed from play and not allowed to return to the sport until cleared by a licensed health care provider trained in the management of head injury and concussion.

Permission - I hereby give my consent for the above named student to compete in sports. I authorize the student to go with and be supervised by a representative of the school on any athletic trips. In case this student becomes ill or is injured, I authorize a representative of the school to have the student treated and I authorize the medical agency to give treatment.

Proof of Insurance – Every athlete **must have** insurance to cover possible injury. No insurance needs to be purchased if you have private coverage for at least \$1,500 for accidental injury. A non-school related insurance agency that you may purchase insurance from if you do not have your own policy.

Name of Insurance Company _____ **Policy #** _____

Code of Conduct & Ethics – I agree to abide by the VUSD Code of Ethics/VUSD Student Activity Code/CIF Code of Ethics/VUSD Non-discrimination/Harassment AR5145.3.

Drug Testing – I agree to the terms of participation in the Drug Testing Program and pledge not to use androgenic/anabolic steroids and dietary supplements banned by the U.S. Anti-Doping Agency and the substance synesphrine, unless with a written prescription from a licensed health care practitioner to treat a medical condition.

My signature below indicates that I have read and agree to all terms and conditions stated in the VUSD Athletic Handbook and Clearance Packet and that all information I/we have provided is true and correct. I understand that providing false information may affect my athletic eligibility.

Parent/Guardian Signature Date

Student-Athlete Signature Date

Office Use:

_____ Physical – Physical Form completed and signed by a physician.

Cleared for Athletic Competition Date

Visalia Unified School District Athletic Pre-participation Health History – Page 1

This Health History must be Completed for the Student, By Student's Parent/Guardian.....

Student Name _____	Sex _____	Date of Birth _____
ID # _____	Grade _____	School _____ Sport _____
Address _____		Phone _____
In Case Of An Emergency _____		Phone _____
Physician _____		Phone _____

<i>Please Explain Yes Answers in Space Below on Page 2</i>	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?		
2. Do you have an ongoing or chronic illness ?		
3. Have you ever been hospitalized overnight or ever had surgery?		
4. Do you feel stressed?		
5. Are you currently taking any medication ?		
6. Do you take any supplements to lose weight or improve your performance?		
7. Do you have any allergies, i.e. to medications, bees, food?		
8. Have you ever developed hives / rash during exercise?		
9. Have you ever passed out or become dizzy during exercise?		
10. Have you ever had chest pain during exercise?		
11. Do you get more tired than your friends during exercise?		
12. Have you ever had a racing heart or skipped heart beats?		
13. Have you ever had high blood pressure or high cholesterol ?		
14. Have you ever had a heart murmur?		
15. Has any family member or relative died of heart problems or of sudden heart death before the age of 50 ?		
16. Have you ever had a severe viral infection, i.e. mononucleosis or myocarditis?		
17. Has a physician ever restricted you from participation in sports?		
18. Do you have any current skin problems?		
19. Have you ever had a head injury or concussion?		
20. Have you ever been knocked out, become unconscious, or lost your memory?		
21. Have you ever had a seizure?		
22. Do you have frequent or severe headaches?		
23. Have you ever had numbness or tingling in your arms, legs, hands or feet?		
24. Have you ever had a stinger, burning or pinched nerve?		
25. Have you ever become ill from exercising in the heat?		
26. Do you cough, wheeze or have trouble breathing during or after activity?		
27. Do you have Asthma?		
28. Do you have seasonal allergies?		
Athletic Preparticipation Health History- Continued – Page 2	Yes	No

Student Name _____		
Date of Birth _____		
29. Do you have special protective or corrective equipment or devices, (i.e. knee brace, neck roll, foot orthotics, retainer, hearing aid) ?		
30. Have you had any problems with your eyes or vision?		
31. Do you wear glasses, contacts or protective eyewear?		
32. Have you ever had a sprain, strain or swelling after an injury?		
33. Have you broken or fractured any bones or dislocated any joints? If yes, explain which part of your body _____		
34. Do you want to weigh more or less than you are now?		
<u>Important : Explain any “ Yes” Answers here please</u>		

Females Only

35. When was your first menstrual period? _____
36. When was your most recent menstrual period? _____
37. How much time do you usually have from the start of one period to the start of the next?

38. How many periods did you have last year ? _____
39. What was the longest time between periods in the last year ? _____
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Month & Year Immunizations Received in the past ten years:

Tdap _____ **Measles** _____ **Hepatitis B** _____ **Chicken Pox** _____

Other _____

<p>I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. I also provide permission for my child to participate in the Athletic Physical Exam at school.</p> <p>Printed Name of Parent/ Legal Guardian _____</p> <p>Signature of Parent/ Legal Guardian _____ Date _____</p>
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VISALIA UNIFIED SCHOOL DISTRICT
***HIGH SCHOOL SPORTS PHYSICAL (To be completed by the parent)**

NAME: _____ M _____ F _____ BIRTHDATE _____ ID# _____

ADDRESS _____ PHONE _____ CURRENT GRADE _____

I hereby give consent to the Visalia Unified School District to receive any information concerning my child's health, including via fax from or send to Dr. _____

Signature of parent/guardian _____ Date _____

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(To be completed by the physician)

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____ LAST Tdap/TETANUS _____

Given today:(Date) _____ Tdap _____ MMR _____

Hep B _____ Hep A _____

Normal	Evaluation	Abnormal	Comments
	VISION		
	EYES		
	EARS		
	MOUTH/TEETH		
	NOSE/THROAT/NECK		
	SKIN		
	HEART		
	LUNGS		
	ABDOMEN/VISCERA		
	BACK		
	EXTREMITIES/REFLEXES		
	TESTICULAR SCREENING (MALES ONLY)		

<p>CLEARED..... may compete in:</p> <p>___ ALL SPORTS</p> <p>___ CONTACT SPORTS</p> <p>___ NON-CONTACT SPORTS</p> <p>___ OTHER</p> <p>Comments: _____</p> <p>_____</p> <p>Medical Provider Signature: _____</p> <p style="text-align: center;">MD, DO, NP, or PA only</p> <p>Printed Name: _____</p> <p>Address: _____</p> <p>Phone number: _____</p> <p>Date: _____</p>	<p>NOT CLEARED...until the following are completed:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Medical Provider Signature: _____</p> <p style="text-align: center;">MD, DO, NP or PA only</p> <p>Printed Name: _____</p> <p>Address: _____</p> <p>Phone number: _____</p> <p>Date: _____</p>
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AMERICAN MEDICAL ASSOCIATION DISQUALIFYING CONDITIONS FOR SPORT PARTICIPATION

CONDITIONS	COLLISION	CONTACT	NON CONTACT	OTHER
GENERAL: Acute Infection: Respiratory, genitourinary, infectious mononucleosis, hepatitis, active rheumatic fever, active tuberculosis.	X	X	X	X
Obvious physical immaturity in comparison with other competitors	X	X		
Hemorrhagic Disease: Hemophilia, purpura and other serious bleeding tendencies	X	X	X	
Diabetes: Inadequately controlled	X	X	X	X
Diabetes: Controlled				
Jaundice	X	X	X	X
EYES: Absence or loss of function of one eye	X	X		
RESPIRATORY: Tuberculosis (active or symptomatic)	X	X	X	X
Severe pulmonary insufficiency	X	X	X	X
CARDIOVASCULAR: Mitral stenosis, aortic stenosis, aortic insufficiency, coarctating of aorta, cyanotic heart disease, recent carditis or any etiology	X	X	X	X
Hypertension on organic basis	X	X	X	X
Previous heart surgery for congenital or acquired heart disease*				
LIVER: Enlarged spleen	X	X		
SKIN: Boils, impetigo and herpes simplex gladiatorum	X	X		
SPLEEN: Enlarged spleen	X	X	X	
HERNIA: Inguinal or femoral hernia	X	X	X	
MUSCULOSKELETAL: Symptomatic abnormalities or inflammations	X	X	X	X
Functional inadequacy of the musculoskeletal system, congenital or acquired, incompatible with the contact or skill demands of the sport	X	X	X	
NEUROLOGICAL: History of symptoms of previous serious head trauma or repeated concussions	X			
Controlled convulsive disorder #				
Convulsive disorder not moderately well controlled by medication	X			
Previous surgery on head	X	X		
RENAL: Absence of one kidney	X	X		
Renal disease	X	X	X	X
GENITALIA: Absence of one testicle/Undescended testicle				

COLLISION: Football, Rugby, Hockey, Lacrosse, etc
 CONTACT: Baseball, Soccer, Basketball, Wrestling, Water Polo, etc.
 NON-CONTACT: Cross Country, Track, Tennis, Crew, Swimming, etc
 OTHER: Bowling, Golf, Field Events, Archery, etc.

*Each patient should be judged on an individual basis in conjunction with this cardiologist and operating surgeon.

** Each person should be judged on a individual basis. All things being equal, it is probably to encourage a young boy or girl to participate in a non-contact sport rather than a contact sport. However, if a particular patient has a great desire to play a contact sport, and this is deemed a major ameliorating factor in his/her adjustment to school, associates and the seizure disorder, serious consideration should be given to letting him/her participate if the seizures are moderately well controlled or that the athlete is under good medical management.

*** The Committee approves the concept of contact sports participation for youths with only one testicle or with an undescended testicle (s), except in specific cases such as an inguinal canal undescended testicle (s) following appropriate medical evaluation to rule out unusual injury risk. However, the athlete’s parents and school authorities should be fully informed that participation in contact sports for such youths with only one testicle does carry a slight injury risk to the remaining healthy testicle. Following such an injury, fertility may be adversely affected. But the chances of an injury to a descended testicle are rare, and the injury risk can be further substantially minimized with an athletic supporter and protective device.