

Online Athletic Clearance



1. Visit www.AthleticClearance.com
2. Watch quick tutorial video
3. **Register.** Parents register with valid email username and password. You will be asked to type in a code to verify you are human. If this step is skipped, your account will not activate.
4. Login
5. Select “**New Clearance**” to start the process.
6. Choose the School Year in which the student plans to participate. *Example: Football in Sept 2018 would be the 2018-2019 School Year.*
Choose the School at which the student attends and will compete for.
Choose Sport
7. Complete all required fields for Student Information, Educational History, Medical History and Signature Forms.
8. **Donate** to your athletic program or pay participation fees (private schools only).
9. Once you reach the **Confirmation Message** Print those sheets for each sport, you are participating in, have it signed by parent/guardian and bring that in with completed athletic physical. You have now completed the process.
10. If you would like to register for additional sports/activities, you may check off those sports below the Confirmation Message. Electronic signatures will be applied to the additional sports/activities.
11. All of this data will be electronically filed with your school’s athletic department for **review**. When the student has been **cleared for participation**, an email notification will be sent.

Online Athletic Clearance FAQ

Multiple Sports

Once you complete a clearance for one sport and arrive at the Confirmation Message, **you will have the option to check off additional sports/activities for the current school year.**

If you decide to participate in an additional sport/activity later on, you can access the multiple sport check boxes by clicking on the “Confirmation Message” of your original Clearance for that specific year.

Physicals

The physical form **MUST** be filled out by your doctor and Confirmation page must be brought to the athletic office **BEFORE TRY OUT DATE!**



Godinez Athletics - Get Griz Sports Now!

<https://godinezathletics.com>

Scan the QR code to go directly and get started now!



- Sign up to follow us on Facebook, Twitter & Instagram!
 - Sign up for alerts
- Download VNN app on your phone to follow teams
 - Online athletic clearance now available!

HIGH SCHOOL ATHLETIC PARTICIPATION SCREENING FORM

Name: _____ **Grade:** _____ **M/F** _____
 (PRINT LEGIBLY) Last Name First Name Middle or Nickname (In Fall)
Birthdate: _____ **ID:** _____ **Fall Sport** _____ **Winter Sport** _____
Spring Sport _____

HEALTH HISTORY TO BE COMPLETED BY PARENT OR GUARDIAN

Has your child:

↓ If you answer "YES" to any questions, please explain below ↓

- | | | | |
|-----|---|-----|----|
| 1. | Had a medical illness or injury that has disqualified him/her from athletic participation? | YES | NO |
| 2. | Ever been hospitalized or undergone any surgical operations(s)? | YES | NO |
| 3. | Had an ongoing chronic or serious illness (such as diabetes, kidney problems, seizures or asthma)? | YES | NO |
| 4. | Ever taken any supplements or vitamins to help gain/lose weight or improve athletic performance? | YES | NO |
| 5. | Ever passed out during/after exercise or become ill from exercising? | YES | NO |
| 6. | Ever tired earlier than expected during exercise or complained of extreme fatigue? | YES | NO |
| 7. | Ever had chest pain or unusual/irregular heartbeats during or after exercise? | YES | NO |
| 8. | Had any history of heart problems, heart murmur, high blood pressure or high cholesterol? | YES | NO |
| 9. | Had any family member or relative die before the age of 50 or die of heart-related problems? | YES | NO |
| 10. | Had any family history of specific heart issues? If "YES," check all that apply:
<input type="checkbox"/> Hypertrophic Cardiomyopathy <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Marfan's Syndrome <input type="checkbox"/> Long QT Syndrome | YES | NO |
| 11. | Had any history of concussion, head injury, loss of memory or being unconscious? | YES | NO |
| 12. | Had any history of seizures, convulsions or fainting episodes? | YES | NO |
| 13. | Had frequent or severe headaches? | YES | NO |
| 14. | Ever had a "stinger," "burner," or pinched nerve (numbness or tingling down an extremity)? | YES | NO |
| 15. | Had any problems with vision that require glasses, contacts, or protective eyewear? | YES | NO |
| 16. | Born without or missing a kidney, eye, testicle, or any other organ? | YES | NO |
| 17. | Had special protective or corrective equipment/devices that are not usually used for sports?
Examples: knee brace, neck roll, foot orthotics, retainer for teeth, hearing aids? | YES | NO |
| 18. | Been diagnosed with a contagious skin condition within the past month? | YES | NO |
| 19. | Ever broken/fractured any bones or dislocated any joints? | YES | NO |
| 20. | Had any recurring problems with pain or swelling in back, muscles, tendons, bones or joints? | YES | NO |
| 21. | Currently under the care of a physician for any medical, orthopedic or emotional concerns? | YES | NO |
| 22. | Had any history of asthma, allergies to foods, medicines, or stinging insects?
If "YES," what medications are used? Is Epi-Pen needed? _____ | YES | NO |
| 23. | Require any special health procedure(s) during the regular school day or during athletics? | YES | NO |
| 24. | Females Only: Have you had a menstrual period? Y__/N__; Age at first menstrual period: ____; # of periods in last year: ____ | YES | NO |
| 25. | Currently taking any prescription or "over-the-counter" medications or using an inhaler or Epi-Pen? | YES | NO |

If "YES," list all medications:

Medication: _____	Dose: _____	Frequency: _____	
Medication: _____	Dose: _____	Frequency: _____	
Medication: _____	Dose: _____	Frequency: _____	

↓ If you have answered "YES" to any of the above questions, please explain below ↓

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct and I give my permission for a physical exam to be completed.

Date: _____ **Signature of Parent/Guardian:** _____
Signature of Student: _____

PHYSICAL SCREENING BELOW TO BE COMPLETED BY HEALTHCARE PROVIDER THIS IS NOT A COMPLETE PHYSICAL EXAMINATION

	Normal		Normal
General:		Musculoskeletal:	
Appearance		Neck and shoulders	
Eyes, ears, nose, throat		Spine	
Cardiovascular		Arms/hands	
Pulses		Hips/thighs	
Chest and lungs		Knees	
Abdomen		Ankles/feet	
Skin			
Genitourinary (if indicated):			

Visual acuity (Distance): Right: _____ / _____ Left: _____ / _____ <input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected
Height: _____
Weight: _____
Blood pressure: _____
Pulse: _____
DATE OF EXAM: _____

Recommendation: Full activity-No restrictions Activity with restrictions No contact sports No participation Other

Comments: _____
 Examining Healthcare Provider: _____
Signature: _____ **Date:** _____
Phone: _____ **Fax:** _____

Healthcare Provider Office Stamp

