

CAPISTRANO UNIFIED SCHOOL DISTRICT

Physical Clearance Form

Name _____ Grade in 2024-25 _____ 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*

<u>Any past or present:</u>	Yes	No		Yes	No
Problems with vision	_____	_____	Surgeries	_____	_____
Eyeglasses	_____	_____	Dental problems	_____	_____
Contacts	_____	_____	Braces	_____	_____
Problems with hearing	_____	_____	False teeth	_____	_____
Hearing aid.	_____	_____	Painful joints	_____	_____
Blacking out or fainting	_____	_____	Broken bones	_____	_____
Unconsciousness	_____	_____	Body part, date _____	_____	_____
Convulsions,	_____	_____	Knee or ankle problems	_____	_____
seizures	_____	_____	Require support/brace	_____	_____
Heart problems	_____	_____	Need for medication	_____	_____
			Name _____	_____	_____
Rheumatic fever	_____	_____	Menstruation problems	_____	_____
Bleeding disorders	_____	_____	Hernias	_____	_____
Blood sugar problems	_____	_____	Asthma	_____	_____
Hypoglycemia	_____	_____	OTHER HEALTH ASPECTS THE DOCTOR		
Diabetes	_____	_____	AND SCHOOL SHOULD BE AWARE OF:		
Allergies— type _____			_____		
Bee or insect stings	_____	_____	_____		
Hospitalizations	_____	_____	_____		
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 a family 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 <i>both</i> 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: (Physician/Physician's asst/Nurse Practitioner) _____ 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 _____

Student athletes will not be cleared to participate in sports until this physical AND the online account for the 2024-2025 school year has been completed on www.athleticclearance.com