ATHLETIC CLEARANCE PACKET (ACP) for 2013-14 SCHOOL YEAR

Instructions for filling out:

- **High School Activities Certificate**
- **Health History/Doctor Clearance – Parts 1 and 2**

All extra-curricular activities (including athletics) within NMUSD operate free of charge to all of our students. While donations or contributions may be requested, there is no connection to a student's ability to participate and their ability/willingness to contribute financially.

Additionally, all NMUSD athletic teams operate with the understanding that selection will be based solely on demonstrated performance and not due to any outside affiliations (e.g. Club Teams) nor participation in off-season voluntary fee based athletic camps.

Please read and follow directions carefully as there have been changes made to these forms!

Activities Certificate:

1) Start at the top and work your way down…
2) List of all sports intending to participate in
3) Name, address, grade, male/female (circle one), home phone, alternate phone, cell phone, date of birth, parent email, last school attended.
4) Parent, please read both sections I and II, sign and date. Under item II, please name an emergency contact and their phone number (preferably a cell phone).
5) Section III, date of physical and office stamp of doctor and doctor's signature. Parent, please list any allergies or medications student is taking.
6) Section IV, Insurance Certification: please enter name and address of your health insurance carrier, sign and date. Initial indicating you have read the District's website policy on insurance. Make a copy of your insurance card and attach it. *If you do not have personal health insurance, it may be purchased. Get the forms from the office.*
7) Section V, Student is to read this section and sign and date it.

Health History form:

1) Please fill out top half of form, either by parent or student before submitting to doctor.
2) Doctor should complete lower portion of this form
3) Name and address of doctor and obtain signature or initials (if front of form was signed).

Code of Ethics – Athletes – will be part of the online Registration Process

Code of Ethics – Parents – will be part of the online Registration Process

Concussion Fact Sheet – will be part of the online Registration Process

Please return this entire packet to the Athletic Office at your school!
Until this is done, your student is not permitted to practice or play.
Thank you!

Corona del Mar High School • Athletics • 949/515-6008

Sports: _____ Received in Athletic Office: _____

Please list any and all you intend to compete in or try out for. Date (for Office Use only)

HIGH SCHOOL ACTIVITIES FORM

(A new form must be on file in the Athletic Office each school year student participates in a sport)

Student's Name: _____ M / F 9 10 11 12 Home Phone: _____

Last First Sex Grade Alt. Phone: _____

Address: _____ Cell Phone: _____

Date of Birth: _____ Parent Email: _____ School Last Attended: _____

PARENT'S OR GUARDIAN'S PERMIT

I. I hereby give my consent for the above-named student to compete in the Newport-Mesa Unified School District's approved activity program such as sports, marching band, drill te etc., and travel with the school reprsentative on necessary school trips. I realize that there is a risk of serious injury from participation in school sports and related activities. It is understood that the school district, the student body, and/or any of the employees are not financially responsible in case of accident or injury.

The undersigned also agrees to be responsible for the **safe return of all equipment** issued by the school to the above-named student:

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

CONSENT FOR EMERGENCY TREATMENT

II. I hereby give permission to a physician to administer emergency treatment.

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

The team physician, trainer,or coach may apply first aid treatment until emergency assistance arrives. _____yes _____no

In an **Emergency**, if Parent/Guardian cannot be contacted, please contact:

Name: _____ Phone: _____

III. PHYSICIAN'S CERTIFICATION

I hereby certify that the above-named student was given a general physical examination and, based on that examination, no illnesses or defects were found which should preclude him/her from engaging in programmed school athletics.

Date: _____ **Physician's Signature:** _____

List Allergies/Medications:

_____

_____

_____

_____

Please Place Physician's Office Stamp Here:

IV. **INSURANCE CERTIFICATION:** I have read the Ed Code requirements at www.nmusd.us/insurance_____ **(please initial)** which states that insurance is required. I hereby certify that the above-named student is covered by accident insurance which provides protection for accidental bodily injury as required by Education Code Sections 32220-32221 for participation in approved school activities during the **2013 to 2014** school year. I understand that the above-named student will be permitted to participate in the District's activity program only upon my representation that insurance coverage as described in Section IVA or IVB is in effect for the present schoolyear. *If there is a change in insurance, it is the parent's responsibility to notify the school.*

A *OR* B must be completed for certification

A. Home Carrier Insurance Plan -- **Must attach copy of insurance card**

_____

Name and Address of Insurance Company

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

B. District-offered insurance plan must be purchased by parent/guardian. (This is offered if the student is not otherwise insured.)

- ☐ 1 School Time Plan (DOES NOT INCLUDE TACKLE FOOTBALL)
- ☐ 2 Full Time 24-Hour Plan (DOES NOT INCLUDE TACKLE FOOTBALL)
- ☐ 3 Tackle Football Plan (DOES NOT INCLUDE SCHOOL OR FULL TIME PLAN)

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

V. STUDENT CERTIFICATION

I agree to abide by the California Interscholastic Federation, League, and school rules of eligibility. I am not a member of any fraternity, unsponsored club, or unauthorized secret society as described in the Education Code and California Interscholastic Federation handbook, nor will I join one.

Date: _____ **Signature of Student:** _____

Newport - Mesa Unified School District

Yes	No	**PART ONE** (completed by parent/guardian or student) --- Circle questions you don't have answers to. Explain "Yes" answers below.
☐	☐	Have you had a medical illness or injury since your last check-up or sports physical?
☐	☐	Have you ever been hospitalized over night?
☐	☐	Have you ever had surgery?
☐	☐	Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?
☐	☐	Have you ever taken any supplements or vitamins to help you gain or lose weight to improve your performance?
☐	☐	Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?
☐	☐	Have you ever had a rash or hives develop during or after exercise?
☐	☐	Have you ever passed out during or after exercise?
☐	☐	Have you ever been dizzy during or after exercise?
☐	☐	Have you ever had chest pain during or after exercise?
☐	☐	Do you get tired more quickly than your friends do during exercise?
☐	☐	Have you ever had racing of your heart or skipped heartbeats?
☐	☐	Have you had high blood pressure or high cholesterol?
☐	☐	Have you ever been told you have a heart murmur?
☐	☐	Has any family member or relative died of heart problems of sudden death before age 50?
☐	☐	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the past month?
☐	☐	Has a physician ever denied or restricted your participation in sports for any heart problems?
☐	☐	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?
☐	☐	Have you ever been knocked out, become unconscious or lost your memory?
☐	☐	Have you ever had a seizure?
☐	☐	Do you have frequent or severe headaches?
☐	☐	Have you ever had numbness or tingling in your arms, hands, legs or feet?
☐	☐	Have you ever had a stinger, burner or pinched nerve?
☐	☐	Have you ever had a head injury or concussion?
☐	☐	Have you ever become ill from exercising in the heat?
☐	☐	Do you cough, wheeze or have trouble breathing during or after activity?
☐	☐	Do you have asthma?
☐	☐	Do you have seasonal allergies that require medical treatment?
☐	☐	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth or hearing aid)?
☐	☐	Have you had any problems with your eyes or vision?
☐	☐	Have you ever had a sprain, strain or swelling after an injury?
☐	☐	Have you ever broken or fractured any bones or dislocated any joints?
☐	☐	Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?

If yes, check appropriate box and explain below.

☐	Head	☐	Chest	☐	Elbow	☐	Wrist	☐	Hip	☐	Ankle
☐	Neck	☐	Shoulder	☐	Hand	☐	Thigh	☐	Knee	☐	Foot
☐	Back	☐	Upper Arm	☐	Finger	☐	Forearm	☐	Shin/calf		

☐	☐	Do you want to weigh more or less than you do now?
☐	☐	Do you lose weight regularly to meet requirements for your sport?
☐	☐	Do you feel stressed out?

Record the dates of your most recent immunizations (shots) for: _____ Tdap

_____ Tetanus _____ Measles _____ Hepatitis B _____ Chicken Pox

Females Only

When was your first menstrual period? _____

When was your most recent menstrual period? _____

How many periods have you had in the past year? _____

Explain "Yes" answers below:

_____

_____

_____

PART TWO --- PRE-PARTICIPATION SPORTS PHYSICAL EXAMINATION (to be completed by physician)

Height_____ Weight _____ Pulse _____ Blood Pressure _____

	Normal	Abnormal Findings	Initials*		Normal	Abnormal Findings	Initials*
MEDICAL				MUSCULOSKELETAL			
Appearance				Neck			
Eyes/Ears/Nose/Throat				Back			
Lymph nodes				Shoulder/Arm			
Heart				Elbow/Forearm			
Pulses				Wrist/Hand			
Lungs				Hip/Thigh			
Abdomen				Knee			
Genitalia (males only)				Leg/Ankle			
Skin				Foot			

☐ Cleared without restriction

☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Physician (print/type) _____ Date _____

Address _____

Signature of Physician _____

N-MUSD 3/3/10