

Oxnard Union High School District—Athletic Clearance Form Insurance Requirement / Parent Authorization / Physician Certification

THIS AUTHORIZATION COVERS THE SCHOOL YEAR: JUNE _____ 20_____ TO JUNE _____ 20_____

Last Name	First Name	Initial	Grade	Date of Birth	Sex
Address			Phone Number		
Emergency Phone	Father's Work Phone	Mother's Work Phone			
Name of Family Physician	Telephone #	Student #		ASB Card #	

• Declaration of Insurance Section

Oxnard Union High School District Board Policy 5143, in accord with Education Code 32221, requires protection for medical and hospital expenses resulting from accidental bodily injury for each member of school athletic teams. The cost is to be paid by each participant. Options providing for minimum coverage requirements as contained with the Education Code are shown below:

- (a) A group or individual plan with accidental benefits of at least \$200 for each occurrence and major medical coverage of at least \$10,000, with no more than \$100 deductible and not less than 89% payable for each occurrence. (NOTE: RETIRED MILITARY COVERS ONLY 75%)
- (b) Group or individual medical plans certified by the Insurance Commissioner to be equivalent to the required coverage of at least \$1,500.
- (c) At least \$1,500 for all such medical and hospital expenses.

Student insurance designed to assist compliance with Education Code requirements is available. Forms are available from the school. If you have applied for student insurance, please indicate so below. If the student has other health or accident insurance that meets the minimum requirements shown above, please list the company name and policy number: PLEASE INDICATE IF YOU ARE (circle one) RETIRED or ACTIVE MILITARY

INSURANCE COMPANY NAME: _____ POLICY/GROUP # _____

ATTENTION: Many insurance companies exclude TACKLE FOOTBALL. Please check your policy carefully, or contact your insurance carrier.

• Parent Authorization / Informed Consent / Assumption of Risk Section

I understand and acknowledge that athletic activities, by their very nature, pose the potential risk of serious injuries/illnesses to the participant, which may include, but are not limited to: **sprains, fractured bones, unconsciousness, head/back injuries, paralysis, loss of eyesight, communicable diseases, and death.** I further understand that participation in athletics is voluntary. I hereby grant permission for the above-named student to participate in the interscholastic sports program of the school and to go with a representative of the school on *any* trips. Furthermore, I release the Oxnard Union High School District and its employees, agents, officers, and volunteers from any liability connected therewith, and I agree to assume all liability for potential risks associated with athletic participation. In the event that this pupil is injured, I grant permission for a school representative to have him/her treated. I also certify that above-named student is covered by insurance that meets the requirement of the California law (at least \$1,500 medical and hospital benefits). I agree to notify the school if any of the above coverage should change. Lastly, I have read and agree to follow the athletic code of conduct.

Athlete Signature _____ Parent Signature _____ Date _____

• Physical Examination Section

Note to Physician: The standard *Medical History Form* used in your office should be completed prior to the examination. If needed, a form may be downloaded at: <http://www.ouhsd.k12.ca.us/studentsandparents/docs/medHistory.pdf>

Height: _____ Weight: _____ Pulse: _____ BP: ____/____ (____/____, ____/____) Vision Corrected: Y / N Pupils Equal: Y / N

Area	Normal	Abnormal	Area	Normal	Abnormal	Area	Normal	Abnormal
Ears/Nose/ Throat			Heart			Orthopedic		
Thyroid			Lungs			Posture		
Lymph Glands			Abdomen			Reflexes		
Skin			Hernia			Muscular		

ABNORMAL HISTORY/FINDINGS: _____

ALLERGIES: _____ REGULAR MEDICATIONS: _____

COMMENTS: _____

CLEARED FOR ATHLETICS NOT CLEARED –Reason: _____

Name of Physician: _____ *Physician Signature: _____ Date: _____

Address: _____ State License #: _____

* The above-signed physician is NOT responsible for any ensuing medical problems or litigation.

This form must be on file with the school of attendance for verification of eligibility prior to participation in any athletic event