ATHLETIC CLEARANCE PACKET

Please complete and sign all forms inside

☐ 1. Student-Athlete Information (Provide Information)

☐ 2. Declaration of Insurance (Provide Information)

☐ 3. Parent Authorization/Consent (Athlete & Parent Signature)

☐ 4. Athletic Code of Ethics (Athlete & Parent Signature)

☐ 5. Medical History (Provide Info & Parent Signature)

☐ 6. Physical Examination (Physician’s Signature)

☐ 7. Concussion Awareness (Athlete & Parent Signature)

☐ 8. Emergency Cards (3) (Provide Info & Parent Signature)
INSTRUCTIONS
In order for students to participate in try-outs, practices, scrimmages and/or games, they must **fully complete** this packet and turn it in to the Athletic Office at their respective school sites. The information in this packet is offered in English on the right-hand page and Spanish on the left. However, all information should be entered on the English forms. Please fill out all 3 Emergency Cards, as they will be given to coaches each season.

Once the packet has been completed, coaches will receive the Emergency Card indicating that the student has been cleared for athletic participation. Students must maintain a 2.0 GPA or higher to participate in athletics.

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INSTRUCCIONES
Para que los estudiantes participen en audiciones, prácticas, y/o partidos deportivos, tienen que **llenar completamente** este paquete y entregarlo a la Oficina Deportiva en su escuela. La información en este paquete se ofrece en inglés en la página a la derecha y español a la izquierda. Sin embargo, **solamente las formas en inglés deben ser llenadas**. Por favor, llenen las 3 tarjetas de emergencia, como se les dan a los entrenadores de cada temporada.

Cuando se completa el paquete, los entrenadores recibirán las tarjetas de emergencia indicando que el estudiante ha sido aprobado por participación deportiva. Los estudiantes tienen que mantener un promedio de calificaciones de 2.0 o más alta para participar en el programa de deportes.
1 • Student-Athlete Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Initial</th>
<th>Grade</th>
<th>Date of Birth</th>
<th>Sex</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Phone Number</th>
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<table>
<thead>
<tr>
<th>Mother’s Name</th>
<th>Mother’s Cell Phone</th>
<th>Mother’s Work Phone</th>
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</table>

<table>
<thead>
<tr>
<th>Father’s Name</th>
<th>Father’s Cell Phone</th>
<th>Father’s Work Phone</th>
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</table>

<table>
<thead>
<tr>
<th>Name of Family Physician</th>
<th>Telephone #</th>
<th>Student #</th>
<th>ASB Card #</th>
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</table>

2 • Declaration of Insurance

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.

3 • Parent Authorization / Informed Consent / Assumption of Risk

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 this 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.

X ________________________________
Athlete Signature

X ________________________________
Parent Signature

______________
Date
4 • Athletic Code of Ethics / Conduct

Athletics is an integral part of the school’s total educational program. All school activities, curricular and extra-curricular, in the classroom and on the playing field, must be congruent with the school’s stated goals and objectives established for the intellectual, physical, social and moral development of its students. It is within this context that the following Code of Ethics is presented.

As an **ATHLETE**, I understand that it is my responsibility to:

- Place academic achievement as the highest priority.
- Show respect for teammates, opponents, officials and coaches.
- Respect the integrity and judgment of game officials.
- Exhibit fair play, sportsmanship and proper conduct on and off the playing field.
- Maintain a high level of safety awareness.
- Refrain from the use of profanity, vulgarity and other offensive language and gestures.
- Adhere to the established rules and standards of the game to be played.
- Respect all equipment and use it safely and appropriately.
- Refrain from the use of alcohol, tobacco, illegal and non-prescriptive drugs, anabolic steroids or any substance to increase physical development or performance that is not approved by the United States Food and Drug Administration, Surgeon General of the United States or American Medical Association.
- Know and follow all state, section and school athletic rules and regulations as they pertain to eligibility and sports participation.
- Win with character, lose with dignity.

As a **PARENT**, I understand that it is my responsibility to:

- Try my best to make athletics a positive experience for everyone involved, i.e., participants, coaches, officials, and spectators.
- Be a positive role model for my child and encourage sportsmanship by showing respect at every game, practice or sporting event.
- Insist my player treat other players, coaches, officials, and fans with respect.
- Teach my child to play by the rules and to resolve conflicts without resorting to hostility or violence.
- Reinforce the school’s drug and alcohol free policies and refrain from any use of alcohol and other drugs before or during contests.
- Do my best to understand and appreciate the rules of the contest.
- Show appreciation for an outstanding play by either team.
- Be a “team” fan, not a “my child” fan.
- Help my child learn that success is measured by the development of skills, not winning or losing.
- Talk to the coach regarding any concern at the **appropriate** time and place, i.e., never before, during, or immediately after a contest and never in front of other parents or players.
- Respect the officials and their authority during games and will never question or confront officials or coaches at a game.
- Refrain from coaching my child or other players during games and practices, unless I am one of the official coaches of the team.
- Do my best to remember my ticket to a school athletic event provides me with the privilege of observing the contest, not berating officials, coaches, or players.

**ACKNOWLEDGEMENT OF CODE OF ETHICS/CONDUCT**: I have read the above and acknowledge that severe or continual violations of this code will result in administrative action, which could include suspension or removal from a team for athletes, and expulsion or suspension from attending athletic events for parents/adults.

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Printed Name of Student Athlete

_______________________________

Signature of Student Athlete

Date

_______________________________

Signature of Parent/Caregiver

Date
5 • Student-Athlete Medical History

Name: ____________________________________ Date of Birth: ______________________

--THIS FORM TO BE COMPLETED BY THE ATHLETE’S PARENT(S) PRIOR TO THE PHYSICAL EXAMINATION--

FAMILY HISTORY
Has anyone in your immediate family had any of the following (circle all that apply):

<table>
<thead>
<tr>
<th>Heart Disease</th>
<th>Diabetes</th>
<th>Asthma</th>
<th>High Blood Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>Cancer</td>
<td>Migraine Headaches</td>
<td>Sudden Death (before 50)</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Tuberculosis</td>
<td>Sickle Cell Anemia or Trait</td>
<td>Marfan's Syndrome</td>
</tr>
</tbody>
</table>

PERSONAL HISTORY

1. Have you ever passed out during or after exercise? ___ YES  NO ___
   Have you ever dizzy or lightheaded during or after exercise? ___ YES  NO ___
   Have you ever had chest pain during or after exercise? ___ YES  NO ___
   Have you ever had shortness of breath during or after exercise? ___ YES  NO ___
   Do you tire more quickly than your friends during exercise? ___ YES  NO ___
   Have you ever had high or low blood pressure? ___ YES  NO ___
   Have you ever been told that you have a heart murmur? ___ YES  NO ___
   Have you ever had a racing heart or skipped heartbeats? ___ YES  NO ___

2. Have you ever had a head injury? ___ YES  NO ___
   Have you ever been “knocked out” or suffered a concussion? ___ YES  NO ___
   Do you have recurring headaches or migraines? ___ YES  NO ___

3. Have you ever been dizzy or passed out in the heat? ___ YES  NO ___
   Have you ever suffered a heat-related illness? ___ YES  NO ___
   Have you received intravenous fluids for a heat-related problem? ___ YES  NO ___

4. Have you ever been diagnosed with asthma and/or exercise-induced asthma? If YES, list the medication(s) that you take: 
   Do you have trouble breathing or do you cough during or after activity? ___ YES  NO ___

5. Have you ever had any of the following? Please circle the appropriate condition:

<table>
<thead>
<tr>
<th>Diabetes</th>
<th>Hernia</th>
<th>Colitis</th>
<th>Marfan’s Syndrome</th>
<th>Stomach Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis</td>
<td>Epilepsy</td>
<td>Measles</td>
<td>Mental Illness</td>
<td>Sickle Cell Anemia</td>
</tr>
<tr>
<td>Anemia</td>
<td>Rubella</td>
<td>Depression</td>
<td>Kidney/Bladder Problems</td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td>Insomnia</td>
<td>Mononucleosis</td>
<td>Drug/Alcohol Addiction</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>Leukemia</td>
<td>Tuberculosis</td>
<td>Bleeding Disorders</td>
<td></td>
</tr>
</tbody>
</table>

6. Do you have a loss or impaired function of any paired organ? (eyes, ears, lungs, kidneys, testicles, or ovaries) ___ YES  NO ___

7. Do you wear corrective lenses? ___ YES  NO ___

8. Do you have any skin problems (itching, rashes or acne)? ___ YES  NO ___

9. FOR FEMALES ONLY (optional):
   Have you had menstrual periods within the past 12 months? ___ YES  NO ___
   If YES, how many? ____________ When was your most recent menstrual period? ____________
   Do you have painful or heavy menstrual periods? ___ YES  NO ___
   Do you take any medications during your menstrual periods? ___ YES  NO ___
   Have you had a pelvic examination within the last year? ___ YES  NO ___

10. Have you ever injured (torn, dislocated, fractured, or had repeated swelling) any of the following (circle):

<table>
<thead>
<tr>
<th>Neck</th>
<th>Elbow</th>
<th>Back</th>
<th>Lower Leg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest</td>
<td>Wrist/Hand</td>
<td>Hip/Thigh</td>
<td>Ankle</td>
</tr>
<tr>
<td>Shoulder</td>
<td>Thumb/Fingers</td>
<td>Knee</td>
<td>Foot/Toes</td>
</tr>
</tbody>
</table>
11. Name any recent injuries or illnesses within the last 18 months which resulted in surgery or hospitalization:

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________

12. Name any recent injuries or illnesses within the last 18 months which resulted in lost practice or playing time:

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________

13. Are you currently taking **ANY MEDICATION** on a daily basis? 

   YES  NO

   If, YES, please list the medication and the conditions you are taking it for:

   Medication  Condition

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________

14. Are you allergic to anything? (Medications, Food, Environmental, Insect Bite/Sting, Etc.)

   YES  NO

   If, YES, please list everything you are allergic to:

_________________________________________________________________________________________________________

THE FOLLOWING CONDITIONS REQUIRE SPECIFIC RELEASE FROM YOUR ATTENDING PHYSICIAN CLEARING YOU FROM THE INJURY OR DISORDER BEFORE YOU ARE ALLOWED TO PARTICPATE:

A) Heart murmurs and heart abnormalities
B) Bone and joint surgeries performed within one year of participation
C) Any medical illness or disease which limits physical participation

X

Signature of Parent/Caregiver

Date

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6 • **Annual Physical Examination** (refer to medical history above)

**ATHLETE NAME:** _____________________________  **Date of Birth:** _____________________________

**Ht:** _____  **Wt:** _____  **Pulse:** _____  **BP:** _____/_____  (_____/_____)  **Vision Corrected:** Y / N  **Pupils Equal:** Y / N

<table>
<thead>
<tr>
<th>Area</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Area</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Area</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ears/Nose/Throat</td>
<td></td>
<td></td>
<td>Heart</td>
<td></td>
<td></td>
<td>Orthopedic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid</td>
<td></td>
<td></td>
<td>Lungs</td>
<td></td>
<td></td>
<td>Posture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph Glands</td>
<td></td>
<td></td>
<td>Abdomen</td>
<td></td>
<td></td>
<td>Reflexes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td>Hernia</td>
<td></td>
<td></td>
<td>Muscular</td>
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</tr>
</tbody>
</table>

**ABNORMAL HISTORY/FINDINGS:**

**ALLERGIES:** _____________________________  **REGULAR MEDICATIONS:** _____________________________

**COMMENTS:**

☐ **CLEARED FOR ATHLETICS**  ☐ **NOT CLEARED** – Reason: _____________________________

**Name of Physician:** _____________________________  * **Signature:** X _____________________________  **Date:** _____________________________

**Address:** __________________________________________  **State License #:** _____________________________

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

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

- Headaches
- “Pressure in head”
- Nausea or vomiting
- Neck pain
- Balance problems or dizziness
- Blurred, double, or fuzzy vision
- Sensitivity to light or noise
- Feeling sluggish or slowed down
- Feeling foggy or groggy
- Drowsiness
- Change in sleep patterns
- Amnesia
- “Don’t feel right”
- Fatigue or low energy
- Sadness
- Nervousness or anxiety
- Irritability
- More emotional
- Confusion
- Concentration or memory problems (forgetting game plays)
- Repeating the same question/comment

What can happen if my child keeps on playing with a concussion or returns to soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athlete will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete’s safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The new CIF Bylaw 313 now requires implementation of long and well-established return to play concussion guidelines:

“A student-athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and for the remainder of the day.”

and

“A student-athlete who has been removed may not return to play until the athlete is evaluated by a licensed health care provider trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider.”

You should also inform your child’s coach if you think that your child may have a concussion. Remember its better to miss one game than miss the whole season. And when in doubt, the athlete sits out. For current and up-to-date information on concussions you can go to: [http://www.cdc.gov/ConcussionInYouthSports/](http://www.cdc.gov/ConcussionInYouthSports/)
8a • Athletic Emergency Card

Name ___________________________ Grade __________ Home Phone (_____) __________________ Age ________

Home Address ____________________________

Father’s Name ___________________________ Cell #: (____) ___________ Work #: (____) ___________

Mother’s Name ___________________________ Cell #: (____) ___________ Work #: (____) ___________

Alternate Contact ________________________ Cell #: (____) ___________ Relationship _______________

Allergies ____________________________________________ Medications ______________________________________

Insurance Company Name: __________________________ Policy/Group #: __________________________

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the above-named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

X__________________________________________Date __________________________

Parent / Guardian Signature

8b • Athletic Emergency Card

Name ___________________________ Grade __________ Home Phone (_____) __________________ Age ________

Home Address ____________________________

Father’s Name ___________________________ Cell #: (____) ___________ Work #: (____) ___________

Mother’s Name ___________________________ Cell #: (____) ___________ Work #: (____) ___________

Alternate Contact ________________________ Cell #: (____) ___________ Relationship _______________

Allergies ____________________________________________ Medications ______________________________________

Insurance Company Name: __________________________ Policy/Group #: __________________________

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the above-named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

X__________________________________________Date __________________________

Parent / Guardian Signature

8c • Athletic Emergency Card

Name ___________________________ Grade __________ Home Phone (_____) __________________ Age ________

Home Address ____________________________

Father’s Name ___________________________ Cell #: (____) ___________ Work #: (____) ___________

Mother’s Name ___________________________ Cell #: (____) ___________ Work #: (____) ___________

Alternate Contact ________________________ Cell #: (____) ___________ Relationship _______________

Allergies ____________________________________________ Medications ______________________________________

Insurance Company Name: __________________________ Policy/Group #: __________________________

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the above-named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

X__________________________________________Date __________________________

Parent / Guardian Signature