LOS ALAMITOS UNIFIED SCHOOL DISTRICT
MEDICAL CLEARANCE – PHYSICAL FORM

Please Complete the Following Checklist to Clear your Student for Team Sports:

1. Complete this form by filling in all necessary information ☐
2. Bring form to your physician for an exam, approval signature and **mandatory stamp** ☐
3. Scan and email form to rpennala@losal.org (preferred) or deliver to Activities Office ☐
4. Go to www.athleticclearance.com, create an account, answer questions and sign electronically ☐

Student Name_____ School Year _____
Last First Middle

School_____ Grade_____ Male ☐ Female ☐

Sport/Activity (1)_____(2)_____(3)_____

Home Address_____
City Zip Code

Parent(s)/Guardian(s) Names_____

_____ _____ _____ _____ _____
Home Phone Father's Work Ph Father's Cell Mother's Work Ph Mother's Cell

If Parent Cannot be Reached:

_____
Name City Relationship Phone #

_____
Name City Relationship Phone #

_____
Student's Physician Address City Phone #

_____
Health Insurance (including Myers-Stevens/Great Republic/Medical) Policy # Name of Insured (required by law)

Authorization for Treatment

I/We, the undersigned parent(s), or guardian(s), of the above-named student-athlete of Los Alamitos High School, do hereby consent, in advance, to any X-ray, examination, anesthetic, medical or surgical diagnosis, or treatment (Medical or Dental) which is deemed advisable by, and is to be rendered either by or under the direction of, any available physician(s) (holding a license to practice in the state of California), whether such activity is performed at the school, at the doctor's office, at the hospital, or other place, when such medical service is necessitated by the student-athlete's participation in the school's athletic program.

It is understood that this authorization given in advance of such X-ray, examination, diagnosis or treatment and that neither the school, nor any school representatives, nor the physician involved, assumes any financial responsibility for exercising this action.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions to the above_____

This authorization shall remain effective for this current school year – August 1 through July 31

Declaration for Mandatory Medical/Hospitalization Insurance for Athletics

I/We understand that Education Code 32221 requires that a member of a school athletic team, a student selected by the school to directly assist in the conduct of an athletic event or students participating in specified co-curricular activities must have a least $1,500 hospitalization and medical insurance coverage.

INCOMPLETE FORMS WITHOUT PHYSICIANS STAMP WILL NOT BE ACCEPTED
KEEP A COPY FOR YOUR FILES - ACTIVITIES IS NOT RESPOSNIBLE FOR COPIES

_____
Parent/Guardian Signature Parent Email Date Student Email

MEDICAL INFORMATION

Child's Name_____ Birth Date_____
Last First Middle

Does the child suffer from a serious medical condition? Yes ☐ No ☐

If yes, is medication required? Yes ☐ No ☐

Is condition life threatening? Yes ☐ No ☐

Does the child suffer from allergies, headaches or menstrual cramps? Yes ☐ No ☐

If yes, is medication required? Yes ☐ No ☐

If you answered yes to any of the above questions, please list condition and any medication prescribed:

_____

List any special instructions: _____

Medication for Co-Curricular Activities – Only medication listed here may be carried by the student and taken during school-sponsored co-curricular activities. A copy of these orders must be carried with the medication at all times – a Xerox copy is acceptable.

Name of Medication	Dose	Frequency	Reason for Medication

Controlled substances such as Ritalin, Adderall, etc. must be carried and administered by a school–designated adult

I, _____(student name) have read the medication procedure and agree to follow it. I will carry only the medication listed above, in an appropriately labeled container. I will take any medication responsibly and will keep it in my activity bag. I WILL NOT SHARE IT OR GIVE IT TO ANY OTHER STUDENT OR INDIVIDUAL. I understand that I will lose the privilege of carrying medication and self-administering my medication if there is any incidence of misuse or abuse

_____
Student Signature Date

_____
Parent Signature Date

PHYSICIAN'S CLEARANCE

☐ I have examined the above-named student and feel that he/she is physically capable of participating in competitive interscholastic athletics.

☐ The medication listed above, with the exception of controlled substances, is to be carried by the student for administration during co-curricular activities.

_____
Physician's Signature Medical License Number Date

PHYSICIAN'S OFFICE STAMP (MANDATORY)

(*Physician's signature & stamp needed for all medication orders and sports physical clearance. Not necessary for field trips)*