

Check Your Sport(s):

LATHROP ATHLETIC CLEARANCE

School Year _____ - _____

FALL

- Football
- Girls Volleyball
- Girls Golf
- Girls Tennis
- Cross Country
- Water Polo

SPRING

- Boys Tennis
- Boys Golf
- Softball
- Baseball
- Swimming
- Track & Field
- Boys Volleyball

Last Name: _____ Grade: _____

First Name: _____ Age: _____ D/O/B: _____

Address: _____

Parent's Name: _____ Contact #: _____

WINTER

- Boys Basketball
- Girls Basketball
- Wrestling
- Boys Soccer
- Girls Soccer

Activities:

- Powder Puff
- CHEER

Have you attended any other high school? Yes ___ No ___
If you answered yes please list the name of the school: _____

This medical history and exam is only intended to determine ability to participate in sports and is not a substitute for regular exams by your physician.

Have you ever had any of the following (please circle Y or N):

YES	NO		YES	NO	
Y	N	1. Head Injury	Y	N	12. Anemia, leukemia or other blood disorder
Y	N	2. Back or neck problems or curvature of the spine	Y	N	13. Diabetes
Y	N	3. Broken Bones, dislocations, or amputations	Y	N	14. Hernia, kidney problem, testicle problem
Y	N	4. Polio or problems with foot, knee, or other joints	Y	N	15. Enlarged spleen or liver
Y	N	5. Eye injury, eye surgery, eye disease	Y	N	16. Surgery other than tonsils
Y	N	6. Wear glasses, contacts, hearing aid or dentures	Y	N	17. Family history of sudden death
Y	N	7. Headaches-other than minor headaches	Y	N	18. Presently taking any medication (list below)
Y	N	8. Drug addiction, mental illness, nervous disorder	Y	N	19. Allergic to medicine, foods, bee stings, etc.
Y	N	9. Epilepsy, fits, fainting, or dizzy spells	Y	N	20. Do you have any ongoing medical problems
Y	N	10. Lung trouble, shortness of breath, asthma	Y	N	21. Do you know of any reason why you should not participate in sports? _____
Y	N	11.Heart trouble, rheumatic fever			Date of last tetanus immunization (recommended every 3 years) _____

Current Medications _____

Exam is good only for current school year **PHYSICIANS PHYSICAL EXAM** **NO CHIROPRACTOR Exams Accepted**
*****Physicals must be done after May 15th to be valid for the following school year*****

Date: _____ B/P: _____ Sex: M or F Weight: _____ Height: _____

I have examined this student and have found him / her: (check one) Fit for Sports In need of further evaluation:

Reason: _____

Physician Signature _____

Place physician stamp here

Office Phone: _____ Physicians Stamp: _____

MEDICAL INSURANCE

California law (Education Code Sections 3220-21) requires every member of any interscholastic athletic team, as well as those associated directly with any interscholastic team, athletic event, including song and cheerleaders, team mascots, team managers, etc. to possess accidental bodily insurance providing at least \$1500 of scheduled medical and hospital benefits. Please specify on the form below the required insurance coverage that you have provided for your son/daughter.

(Company Name) (Group or Policy #)
I WILL PROMPTLY NOTIFY THE SCHOOL IN THE EVENT INSURANCE COVERAGE NO LONGER APPLIES TO MY SON/DAUGHTER.

EMERGENCY INFORMATION (Person to contact if parents cannot be reached)

Name: _____ Phone: _____

For Office Use Only:
 CIF Yes ___ No ___ Cleared by: _____
 Submitted _____ Date: _____
 Approved _____ Office Copy: