

ONLINE ATHLETIC CLEARANCE

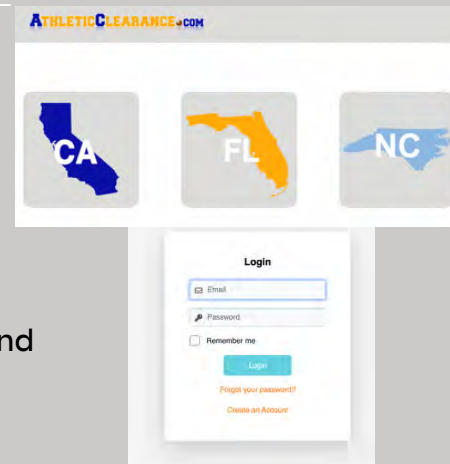
1 VISIT [ATHLETICCLEARANCE.COM](https://athleticclearance.com) CHOOSE CALIFORNIA LOG INTO ACCOUNT

Return Users

Log into existing account used in previous School Year.

New Users

Create an account. Please register with a valid PARENT/GUARDIAN email address as the username and generate a password.



2 SELECT START CLEARANCE HERE

Type in School & Confirm Address
Select Year
Add Sports

Participating in multiple sports? Use Add New Sport button. Athletes participating in multiple sports will have to create clearances for each sport.



3 COMPLETE ALL REQUIRED FIELDS

Student Information, Parent/Guardian Information, Medical History, Signature Forms, and upload any File(s).


Student Info & Parent Guardian Info

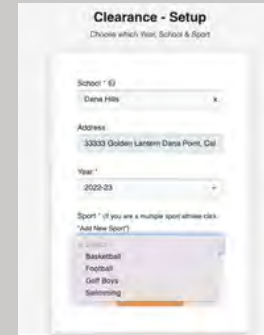
Type in Student & Parent/Guardian Information. This information will be saved for future clearances. Utilize the drop down menu to autofill information for subsequent clearances.

Signatures

Sign required documents by typing in an EXACT match of what is on the Student & Parent/Guardian page.

Files

Click  to add a file. Browse from your computer for the file or select Choose Existing File to search for a previously uploaded file.



**MAKE SURE TO CLICK SAVE & CONTINUE
AFTER COMPLETING THE FILES PAGE TO
SUBMIT THE CLEARANCE.**

4 CONFIRMATION MESSAGE

Your clearance is ready for review by your school once you have reached the CONFIRMATION MESSAGE page.



**THE STUDENT IS NOT CLEARED YET!
THE SCHOOL MUST REVIEW AND CLEAR THE STUDENT. AN EMAIL NOTIFICATION WILL BE
SENT ONCE THE SCHOOL HAS REVIEWED AND CLEARED THE STUDENT FOR PARTICIPATION.**

CONTACT HOME CAMPUS

SUPPORT@HOMECAMPUS.COM

[ATHLETIC CLEARANCE HELP ARTICLES](#)

Please Have These Items Handy When Completing Your Athletic Clearance Packet

See below for what you will need to have ready to upload to your Student-Athlete account in order to be cleared to participate in CDM High School Athletics:

- HIGH SCHOOL ATHLETIC PRE-PARTICIPATION EXAM FORM** (see below)
The Student-Athlete's Parent or Legal Guardian must complete, sign and date the top portion of this specific form regardless of the physical exam form used by the doctor's office. This form is available on the CDM HS Athletics website.
- PHYSICIAN'S PHYSICAL EXAM & CLEARANCE FORM**
Physician's portion must be signed and dated by a physician and include the doctor's office stamp.
- DIGITAL IMAGE OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARD**
This can be in the form of photographs or scanned images.

USE THIS SPECIFIC FORM
It is available on the CDMHS Athletics website

Regardless of whether or not the physician uses this specific form for the Student-Athlete's physical exam and clearance, the top portion of this specific form must be completed, signed, dated and uploaded to the account by a Parent or Legal Guardian.

HIGH SCHOOL ATHLETIC PRE-PARTICIPATION EXAM FORM Circle One: CDMHS CMHS EHS NHHS

Name: _____ Grade: _____ M/F _____
 (PRINT LEGIBLY) Last First Middle or Nickname
 Birthdate: _____ Student ID #: _____ SPORT: _____ (In Fall) _____ Circle _____
 Fall Winter Spring

Section A: REQUIRED HEALTH HISTORY TO BE COMPLETED BY PARENT OR GUARDIAN
 Has your child: If you answer "YES" to any questions, please explain below.

- Had a medical illness or injury that has disqualified him/her from athletic participation? YES NO
- Ever been hospitalized or undergone any surgical operations(s)? YES NO
- Had an ongoing chronic or serious illness (such as diabetes, kidney problems, seizures or asthma)? YES NO
- Ever taken any supplements or vitamins to help gain/lose weight or improve athletic performance? YES NO
- Ever passed out during/after exercise or became ill from exercising? YES NO
- Ever tired earlier than expected during exercise or complained of extreme fatigue? YES NO
- Ever had chest pain or unusual/irregular heartbeats during or after exercise? YES NO
- Had any history of heart problems, heart murmur, high blood pressure or high cholesterol? YES NO
- Had any family history of specific heart issues? If "YES," check all that apply: YES NO
- Hypertrophic Cardiomyopathy Arrhythmia Marfan's Syndrome Long QT Syndrome
- Had any history of concussion, head injury, loss of memory or being unconscious? YES NO
- Had any history of seizures, convulsions or fainting episodes? YES NO
- Had frequent or severe headaches? YES NO
- Ever had a "stinger," "burner," or pinched nerve (numbness or tingling down an extremity)? YES NO
- Had any problems with vision that require glasses, contacts, or protective eyewear? YES NO
- Had special protective or corrective equipment/devices that are not usually used for sports? YES NO
 Examples: knee brace, neck roll, foot orthotics, retainer for teeth, hearing aids?
- Been diagnosed with a contagious skin condition within the past month? YES NO
- Ever broken/fractured any bones or dislocated any joints? YES NO
- Had any recurring problems with pain or swelling in back, muscles, tendons, bones or joints? YES NO
- Is your child currently under the care of a physician for any medical, orthopedic or emotional concerns? YES NO
- Had any history of asthma, allergies to foods, medicines, or stinging insects? YES NO
 If "YES," what medications are used? _____ Inhaler/Pen needed?
- Does your child require any special health procedure(s) during the regular school day or during athletics? YES NO
- Is your child currently taking any prescription or "over-the-counter" medications or using an inhaler or Ep-Pen? If "YES" Please List All Medication: _____ Dose: _____ Frequency: _____ YES NO
- Does your child have a history of having COVID-19? Date: _____ Dose: _____ Frequency: _____ YES NO
- Has your child received the COVID-19 vaccine? 1st Dose Date: _____ 2nd Dose Date: _____ Booster Dose Date(s): _____ YES NO

If you have answered "YES" to any of the above questions, please explain: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
 Parent/Guardian Signature: _____ Date: _____

Section B: PHYSICAL EXAM REQUIRED FOR ALL ATHLETES: To be completed by HEALTHCARE PROVIDER

General: Normal	Chest/Lungs: Normal	Visual acuity (Distance): Right: / Left: /
Eyes, ears, nose, throat	Neck	<input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected
Cardiovascular	Abdomen	Height: _____ Blood pressure: _____
Femoral pulses	Skin	Weight: _____ Pulse: _____
Musculoskeletal: Normal	Hips/Thighs: Normal	Arms/Hands: Normal
Neck/Shoulder	Knees	Ankles/Feet
Spine		

COMMENTS: _____

Recommendation: Full activity-No restrictions Activity with restrictions (explain below) No contact sports No participation Other

Please explain restrictions: _____

Examining Healthcare Provider (please print): _____
 MD/DO/NP/PA ONLY
 Signature: _____
 DATE OF EXAM: _____ Phone: _____

Healthcare Provider Office Stamp: **Required**
 NOT VALID WITHOUT STAMP

NOT ACCEPTED WITHOUT DATE