NORWALK-LA MIRADA UNIFIED SCHOOL DISTRICT
ATHLETIC INSURANCE CERTIFICATION FORM

Student's Name: ____

School: ____

I hereby certify, under penalty of perjury, that the above-named pupil is covered by valid insurance that provides the following:

(1) Insurance protection for medical and hospital expenses resulting from accidental bodily injuries in one of the following amounts: (Ed. Code 32221)
   (a) A group or individual medical plan with accidental benefits of at least two hundred dollars ($200) for each occurrence and major medical coverage of at least ten thousand dollars ($10,000), with no more than one hundred dollars ($100) deductible and no less than eighty percent (80%) payable for each occurrence.
   (b) Group or individual medical plans which are certified by the Insurance Commissioner to be equivalent to the required coverage of at least one thousand five hundred dollars ($1,500).
   (c) At least one thousand five hundred dollars ($1,500) for all medical and hospital expenses.

(2) I hereby agree that this policy shall not be cancelable without at least 10 days prior written notice to the district.

Insurance protection in any of the above amounts shall be provided through group, blanket, or individual policies of accident insurance from authorized insurers or through a benefit and relief association, such as California Interscholastic Protection Fund, for the death or injury to members of athletic teams arising while such members are engaged in or are preparing for an athletic event promoted under the sponsorship or arrangements of the educational institution or a student body organization thereof or while such members are being transported by or under the sponsorship or arrangements of the school districts or a student body organization thereof to or from school or other place of instruction and the place of the athletic event. Minimum medical benefits under any insurance required by this paragraph shall be equivalent to three dollars and fifty cents ($3.50) conversion factor as applied to the unit values contained in the minimum fee schedule adopted by the Department of Industrial Relations of the State of California, effective October 1, 1966. (Ref. Ed. Code 32221)

I will maintain the above coverage during the current school year or will immediately notify the school if the coverage terminates or does not meet the above requirements.

____

Insurance Company   Policy/Group No.

____

Expiration Date of Policy   Date

____

Parent/Guardian Signature   Parent/Guardian Name (Please Print)

ATHLETIC PHYSICAL

SCHOOL YEAR ____________ SCHOOL ____________ SPORT ____________

INFORMATION TO BE FURNISHED BY PARENT OR GUARDIAN

STUDENT'S NAME ____________ AGE ________ GRADE ________ DATE ____________

ADDRESS ____________ PHONE NUMBER ____________ BIRTHDATE ____________

HEALTH HISTORY (Check and give date)

Diabetes ________ Date ________
Epilepsy ________ Date ________
Hernia ________ Date ________
Heart Murmur ________ Date ________
Rheumatic fever ________ Date ________
Allergies or Asthma ________ Date ________
Frequent headaches ________ Date ________
Other ____________________________

OPERATIONS:
Kind ____ Date ______________

RECENT INJURIES:
Kind ____ Date ______________

Has student received a recent tetanus immunization? ____________________ Date (MO/YR) ______________

Does student have an abnormal condition, such as a "trick" knee or still joint or any restricting disability? ______________

If so, what? ____

____
SIGNATURE OF PARENT OR GUARDIAN

DOCTOR'S REPORT OF PHYSICAL EXAMINATION

EYES (gross abnormalities) ______________________________

EARS (gross abnormalities) ______________________________

TEETH (chipped, capped, partial plates, etc.) ______________________________

HEART ______________________________

LUNGS ______________________________

BLOOD PRESSURE ______________________________

HERNIA ______________________________

ORTHOPEDIC OBSERVATIONS ______________________________

PERTINENT HEALTH HISTORY ______________________________

____

ACCEPTED FOR FULL ATHLETIC ACTIVITY: YES __________ NO __________

ACCEPTED FOR FULL ATHLETIC ACTIVITY EXCEPT FOR: ______________________________

RECOMMENDATIONS: ______________________________

____

____
PHYSICIAN'S SIGNATURE

____________________________ ____________________________
DATE ADDRESS