Check Your Sport(s):

MUSD ATHLETIC CLEARANCE

School Year
_____-_____

FALL
☐Football
☐Girls Volleyball
☐Girls Golf
☐Girls Tennis
☐Cross Country
☐Water Polo
☐Girls Flag Football

WINTER
☐Boys Basketball
☐Girls Basketball
☐Wrestling
☐Boys Soccer
☐Girls Soccer

SPRING
☐Boys Tennis
☐Boys Golf
☐Softball
☐Baseball
☐Swimming
☐Track & Field
☐Boys Volleyball

Activities:
☐**Powder Puff**
☐**CHEER**

Last Name:_____ Grade:_____

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

Address:_____

Parent's Name:_____ Contact #:_____

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	
Y	N	1. Head Injury
Y	N	2. Back or neck problems or curvature of the spine
Y	N	3. Broken Bones, dislocations, or amputations
Y	N	4. Polio or problems with foot, knee, or other joints
Y	N	5. Eye injury, eye surgery, eye disease
Y	N	6. Wear glasses, contacts, hearing aid or dentures
Y	N	7. Headaches-other than minor headaches
Y	N	8. Drug addiction, mental illness, nervous disorder
Y	N	9. Epilepsy, fits, fainting, or dizzy spells
Y	N	10. Lung trouble, shortness of breath, asthma
Y	N	11.Heart trouble, rheumatic fever
Y	N	12. Anemia, leukemia or other blood disorder
Y	N	13. Diabetes
Y	N	14. Hernia, kidney problem, testicle problem
Y	N	15. Enlarged spleen or liver
Y	N	16. Surgery other than tonsils
Y	N	17. Family history of sudden death
Y	N	18. Presently taking any medication (list below)
Y	N	19. Allergic to medicine, foods, bee stings, etc.
Y	N	20. Do you have any ongoing medical problems
Y	N	21. Do you know of any reason why you should not participate in sports? _____

_____ 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: ☐

Updated 9/21/2023