Form 2

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT

ATHLETIC CLEARANCE FORM

SPORTS: (fall)_____ (winter)_____ (spring)_____

Name _____Grade_____ Male ____Female____ Date of birth __/__/__

Address _____ City & Zip Code_____ Home Phone_____

Name of Father/Guardian_____ Work phone _____Cell phone _____

Name of Mother/Guardian _____Work phone_____ Cell phone_____

Emergency Contact_____ Phone Number_____ Insurance _____

I hereby give my consent for the above named student (son/daughter/ward) to compete in sports and to go with a representative of the school on any trips. In case of injury, you are authorized to have him/her treated.

Signature of parent/guardian _____ Date _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT BEFORE DOCTOR EXAM

Any past or present:	Yes	No
Problems with vision		
Eyeglasses		
Contacts		
Problems with hearing		
Hearing aid		
Blacking out or fainting		
Unconsciousness		
Convulsions, seizures		
Heart problems		
Rheumatic fever		
Bleeding disorders		
Blood sugar problems		
Hypoglycemia		
Diabetes		
Allergies – type _____		
Bee or insect stings		
Hospitalizations		

	Yes	No
Surgeries		
Dental problems		
braces		
false teeth		
Painful joints		
Broken bones		
Part, date _____		
Knee or ankle problems		
Require support/brace		
Need for medication		
Name _____		
Menstruation problems		
Hernias		
Asthma		

OTHER HEALTH ASPECTS THE DOCTOR AND SCHOOL SHOULD BE AWARE OF:

_____

_____

PHYSICAL EXAM: DATE _____ HEIGHT _____ WEIGHT _____

PULSE: RESTING _____ AFTER ACTIVITY _____ B.P. _____

EYES	_____	LYMPH GLANDS	_____	POSTURE	_____
EARS	_____	THYROID	_____	MUSCLE TONE	_____
NOSE	_____	HEART	_____	REFLEXES	_____
THROAT	_____	LUNGS	_____	ORTHOPEDIC	_____
TEETH	_____	ABDOMEN	_____	SKIN	_____
BRACES	_____	HERNIA	_____	OTHER	_____

I have examined the above student and do recommend that s/he is physically fit for full participation in sports.

Name of physician _____MD or DO Date_____

Signature _____ Phone number _____

Special doctor recommendations or restrictions _____

_____

****PLEASE STAMP WITH PHYSICIAN'S OFFICE STAMP****

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT

ATHLETIC CLEARANCE FORM

Form 3

Last Name:	**First Name:**	**MI:**

Birth Date:	**Sports/Activity:**		
		Fall	***Winter***	***Spring***

California Law, Education Code, Section 32220-24 requires that every member of a high school athletic team have accidental bodily injury insurance, providing at least $1500 of scheduled medical/hospital benefits. The parent or guardian must provide proof that their family coverage satisfies the Code in relation to medical coverage. If you **have** the $1500, accidental bodily injury insurance, please fill out **ITEM 1** below. If you **do not have** accidentally bodily injury benefits for your son, daughter, or ward, please fill out **ITEM 2** below.

ITEM 1 -- ***MY MEDICAL COVERAGE POLICY FOR AT LEAST $1500 IS ISSUED BY:***

_____ _____

Insurance Company ***Policy Number***

I certify that the student listed above **has** accidental bodily injury insurance providing at least $1500 of scheduled medical/hospital benefits.

_____ / / _____ / /

Student's Signature ***Date*** ***Parent/Guardian Signature*** ***Date***

PROOF OF INSURANCE IS REQUIRED PLEASE ATTACH A PHOTOCOPY OF INSURANCE CARD HERE

ITEM 2

The athlete does not have accidental bodily injury insurance required. **YOU MUST COMPLETE APPROPRIATE MYERS STEVENS & TOOHEY & CO., INC. APPLICATION**

We have subscribed to Myers-Stevens & Toohey & Co., Inc. for athletic insurance, which meet the limits requested. (Myers-Stevens & Toohey & Co. Inc. will send verification of insurance to each school

_____ / / _____ / /

Student's Signature ***Date*** ***Parent/Guardian Signature*** ***Date***