CAPISTRANO UNIFIED SCHOOL DISTRICT

Physical Clearance Form

SPORTS: *(Please check all that apply)*

- o Cross Country
- o Football
- o Girls Golf
- o Girls Tennis
- o Girls Volleyball
- o Boys Water Polo
- o Surfing
- o Basketball
- o Soccer
- o Girls Water Polo
- o Wrestling
- o Baseball
- o Softball
- o Boys Golf
- o Swimming
- o Boys Tennis
- o Track
- o Boys Volleyball
- o Lacrosse

Name_____ **Grade in 2025-26** _____ **Male**_____ **Female**_____ **Date of Birth**____/____/____

Address_____ **City & Zip Code**_____ **Phone**_____

Father/Guardian_____ **Work phone**_____ **Cell phone** _____

Mother/Guardian_____ **Work phone**_____ **Cell phone** _____

Emergency Contact _____ **Phone**_____ **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	____	____
Body 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:

_____

_____

	Yes	No
Any history of chest pain with exercise?	____	____
Any history of "racing" heart or skipped beats?	____	____
Do you experience passing out, near passing out or unexpected tiredness during exercise?	____	____
Any family history of sudden cardiac death in afamily member under the age of 50?	____	____
Any family history of Marfan's syndrome Or prolonged QT syndrome?	____	____
Any history of temporary numbness or paralysis of *both* arms and/or legs following head/spine trauma?	____	____
Any history of recent severe viral illness, infectious mononucleosis, or hepatitis?	____	____
Any history of the following: absence of one kidney?	____	____
males: absence of one testicle?	____	____
Any history of blindness in one eye?	____	____
Any current active skin infection?	____	____

Physical Exam Date:_____ **HEIGHT**_____ **WEIGHT** _____

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

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

Special doctor recommendations or restrictions _____

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

(Must be signed by a **PHYSICIAN, PHYSICIAN'S ASSISTANT or NURSE PRACTITIONER***)*

Name of physician_____ **M.D/DO/PA/NP Date**_____ ****Physician's Office Stamp****

Signature_____ **Phone** _____

This physical plus an online homecampus clearance consitutes physical clearance