| Adolfo Camarillo HS (805) 389-6407 | Channel Islands HS (805) 385-2787 | Hueneme HS (805) 385-2667 | Oxnard HS (805) 278-2907 | Pacifica HS (805) 278-5000 | Rio Mesa HS (805) 278-5500 |
|---|---|---|---|---|---|

# Oxnard Union High School District
# Insurance Requirement / Parent Authorization / Physician Certification Form
# Physical is Valid for a School Year

**Date** _____ **Sport(s)**_____

| Last Name | First Name | Initial | Grade | Date of Birth | Sex |
|---|---|---|---|---|---|
| | | | | | |

| Address | Phone Number |
|---|---|
| | |

| Emergency Phone | Father's Work Phone | Mother's Work Phone |
|---|---|---|
| | | |

| Name of Family Physician | Telephone # | Student # | ASB Card # |
|---|---|---|---|
| | | | |

## • Parent Authorization / Informed Consent / Assumption of Risk Section

I understand and acknowledge that athletic activities, by their very nature, pose the potential risk of serious injuries/illnesses to the participant, which may include, but are not limited to: **sprains, fractured bones, unconsciousness, head/back injuries, paralysis, loss of eyesight, communicable diseases, and death**. I further understand that participation in athletics is voluntary. I hereby grant permission for the above-named student to participate in the interscholastic sports program of the school and to go with a representative of the school on *any* trips. Furthermore, I release the Oxnard Union High School District and its employees, agents, officers, and volunteers from any liability connected therewith, and I agree to assume all liability for potential risks associated with athletic participation. In the event that this pupil is injured, I grant permission for a school representative to have him/her treated. I also certify that above-named student is covered by insurance that meets the requirement of the California law (at leas\t $1,500 medical and hospital benefits). I agree to notify the school if any of the above coverage should change. Lastly, I have read and agree to follow the athletic code of conduct.

Athlete Signature_____ Parent Signature_____ Date_____

## • Annual Physical Examination Section

Height: _____Weight: _____ Pulse: _____ BP: _____/_____ ( ____/____, _____/____ ) Vision Corrected: Y / N Pupils Equal: Y / N

| Area | Normal | Abnormal | Area | Normal | Abnormal | Area | Normal | Abnormal |
|---|---|---|---|---|---|---|---|---|
| Ears/Nose/ Throat | | | Heart | | | Orthopedic | | |
| Thyroid | | | Lungs | | | Posture | | |
| Lymph Glands | | | Abdomen | | | Reflexes | | |
| Skin | | | Hernia | | | Muscular | | |

ABNORMAL HISTORY/FINDINGS: _____

ALLERGIES: _____REGULAR MEDICATIONS: _____

COMMENTS: _____

O **CLEARED FOR ATHLETICS** O **NOT CLEARED –Reason:** _____

Name of Physician/Medical Professional: _____ *Physician Signature: _____

Date:_____

Address:_____State License #:_____

***** The above-signed physician is NOT responsible for any ensuing medical problems or litigation. Form adapted from © 2005 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

**This form must be on file with the school of attendance for verification of eligibility prior to participation in any athletic event**

Please upload this form with Doctor/Medical Practitioner signature to https://www.athleticclearance.com/ and complete all necessary information. The Athletic Director will review submitted information. A student is not cleared for sports until the information has been reviewed and approved by the Athletic Director.