



SPORTS CLEARANCE

MISSION OAK HIGH SCHOOL

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ATHLETIC DIRECTOR: Osama Hamid

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The following items are needed to be cleared to play sports:

- Register on FAMILYID.COM for the current school year
- Drug consent form signed by parents/student
- Up to Date physical (physicals are good for one year after the physical is completed)
- Athletic Registration Form
- Copy of Health Insurance Card or Proof of purchased insurance through the school

FAMILY ID

Sign up for your secure Family ID (www.familyid.com) account by entering your family name, email address and password (*SAVE* your password). You will receive an email with a link to activate your new account. **Family ID will need to be kept current each school year.**

- 1) Visit www.familyid.com
- 2) Click "Find Programs"
- 3) Click "Mission Oak" in the box that says Type Organization Name or Keyword to find program
- 4) Click "Find"
- 5) Click (current school year) Athletic Registration
- 6) Complete the Registration form.
- 7) Hit Submit registration.

DRUG CONSENT

Random drug testing will occur for all athletes. If you are taking a prescription medication, please provide documentation from the doctor to the nurse.

PHYSICAL

Physicals need to be completed by a physician (not chiropractor) and are good for one year after physical is completed. Family ID will send an email out 30 days prior to physical expiration date and it is your responsibility to keep it current.

ATHLETIC REGISTRATION FORM

Information on this form must be accurate and correct. All required signatures must be signed.

INSURANCE

Students are required to provide a copy of their health insurance card or purchase health insurance through the school.

<https://www.peinsurance.com/products/student-insurance/student-accident-insurance/>

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP	/ (/)	Pulse	Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
		Vision R 20/	L 20/
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) [†]			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic [‡]			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[†]Consider GU exam if in private setting. Having third party present is recommended.
[‡]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex M F Age _____ Date of birth _____

- Cleared for all sports without restriction
 Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____
Address _____ Phone _____
Signature of physician _____ MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

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TULARE JOINT UNION HIGH SCHOOL DISTRICT

EXHIBIT "A" STUDENT ATHLETE DRUG TESTING CONSENT FORM

I understand after having read the Drug Testing Policy for the Tulare Joint Union High School District, set forth in Board Policy and Administrative Regulation 5131.61, that out of concern for my safety and health, the Governing Board and the District have established and enforce rules and consequences regarding the use of illegal drugs and controlled substances. I realize that the personal decisions that I make daily in regard to the use of illegal drugs or controlled substances may affect my health and well-being, pose a danger to those around me, and reflect negatively upon the District athletic program with which I am associated. If I choose to violate school policy regarding the use of illegal drugs or controlled substances, I understand that I will be subject to the restrictions of my participation as outlined in the policy

I authorize Tulare Joint Union High School District to conduct a test on a urine specimen, which I provide to test for illegal drugs and controlled substances, including but not limited to those drugs and controlled substances identified in District policy and regulation and/or set forth below. I also authorize the exchange of information concerning the results of such a test between the Tulare Joint Union High School District, my parent(s), and the contracted drug-testing agency, Recovery Resources.

This shall be deemed a consent pursuant to the Family Education Right of Privacy Act (20 U.S.C § 1232g; 34 C.F.R. Part 99) and the Education Code (sections 49076 et seq.) for the release of the above information to the parties named above.

The testing service will include tests for, but not limited to, one or more of the following illegal drugs and/or controlled substances: marijuana metabolite, cocaine metabolite, opiates, phencyclidine (PCP), amphetamines, alcohol, benzodiazepines, barbiturates, propoxyphene (Darvocet), methadone, oxycontin, designer drugs and steroids.

Parents may withdraw authorization to test students, with written notification to Associate Superintendent at the District Office: 426 N. Blackstone St., Tulare, California 93274. The only consequence for such withdrawal is that the student will no longer be able to participate in District Athletics.

PLEASE INDICATE ANY PRESCRIPTION DRUGS YOUR CHILD IS CURRENTLY TAKING AND PROVIDE DOCUMENTATION TO VERIFY IT WITH THIS FORM:

_____	_____	_____
Print Student's Name	Student's Signature	Date
_____	_____	_____
Print Parent/Guardian's Name	Parent/Guardian's Signature	Date

TULARE JOINT UNION HIGH SCHOOL DISTRICT

Athletic and Activity/Club Registration Form

My student wishes to participate in the following sports/activities:

<input type="checkbox"/> Cross Country <input type="checkbox"/> Baseball <input type="checkbox"/> Softball <input type="checkbox"/> Badminton	<input type="checkbox"/> Flag Football <input type="checkbox"/> Tackle Football <input type="checkbox"/> Hockey <input type="checkbox"/> Swimming	<input type="checkbox"/> Soccer <input type="checkbox"/> Tennis <input type="checkbox"/> Golf <input type="checkbox"/> Water Polo	<input type="checkbox"/> Basketball <input type="checkbox"/> Volleyball <input type="checkbox"/> Cheerleading <input type="checkbox"/> Drill Team	<input type="checkbox"/> Track & Field <input type="checkbox"/> Wrestling <input type="checkbox"/> Band/Orchestra <input type="checkbox"/> Other ()
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All prospective participants must complete these materials, provide proof of medical insurance and have a parent/guardian authorizing their participation prior to participation in any activity or practice.

Mission Oak

Student Name (Please Print)	School	Date of Birth	Grade	Parent Phone Number
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Address- Street	Apt.	City	ZIP
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CALIFORNIA LAW

The California Education Code (Sections 32221-32224 and 49470-49474) requires that each member of an athletic team shall have insurance coverage for medical and hospital expenses in an amount of at least \$1,500 while practicing for or participating in athletic activities under the jurisdiction of a public-school district. "Member of an athletic team" means member of any extramural athletic team engaged in athletic events on or outside the school grounds, maintained or sponsored by the educational institution or a student body organization thereof. Member of an athletic team also includes members of school bands or orchestras, cheerleaders and their assistants, pompon girls, team managers and their assistants, and any student or pupil selected by the school or student body organization to directly assist in the conduct of the athletic event, including activities incidental thereto, but only while such members are being transported by or under the sponsorship or arrangements of the educational institution or a student body organization thereof to or from a school or other place of instruction and the place at which the athletic event is being conducted."

Under state law, school districts are required to ensure that all members of school athletic teams have accidental injury insurance that covers medical and hospital expenses. This insurance requirement can be met by the school district offering insurance or other health benefits that cover medical and hospital expenses. Some pupils may qualify to enroll in no-cost or low-cost local, state or federally insured programs. Information about these programs which include other comparable no-cost or low-cost local, state or federally sponsored health insurance programs, may be obtained by calling 1-800-722-3365 or the Health Families and Medical Programs Information Line at 1-800-880-5305.

SPORTS WARNING STATEMENT

Participating in competitive athletics may result in severe injury, including paralysis or death. Players can reduce the risk by reporting all physical problems to their coaches. Following coaches' instructions regarding playing techniques, training and other team rules, etc. and agreeing to obey such instructions. Even if all these requirements are met, a serious accident may still occur.

QUITTING POLICY

I understand that if I quit any Mission Oak athletic team for reasons other than medical or a personal/family crisis, I will not be allowed to participate in another season of sport in which I quit has concluded, including playoffs.

Print Student's Name	Student's Signature	Date
Print Parent/Guardian's Name	Parent/Guardian's Signature	Date

INSURANCE PROTECTION

Parents/Guardians must provide proof of insurance and complete and sign the following athletic waiver of insurance as evidence of other insurance coverage, or purchase Student Accident Insurance made available by the Tulare Joint Union High School District before the student is eligible to participate in athletic events.

- **OPTION A: Personal Insurance.** I hereby declare that my student, _____, has medical insurance in the amount of at least \$1,500 administered by _____ Insurance Co., Policy #: _____, which will provide coverage for medical and hospital expenses resulting from accidental bodily injury while practicing for or participating in athletic events. Therefore, I do not want my student to subscribe to membership in the insurance program made available through the district for accidental bodily injury and hereby release the Governing Board and school officials of the Tulare Joint Union High School District from any and all responsibility to provide insurance required under California Education Code Section 32220-32224. I WILL NOTIFY THE SCHOOL OF ANY CHANGE OR LAPSE IN THE ABOVE COVERAGE.
- **OPTION B:** I wish to participate in the Student Accident Plan made available by Tulare Joint Union High School District. An insurance enrollment form should accompany this form, or you can obtain one online at the Student Insurance provider website. Log on to www.peinsurance.com. Under "Products", click on "students", then click the appropriate link for a Brochure in English or Spanish. You may also sign up online and print proof of your coverage (attach to this document) OR Print Brochure, complete and bring to your coach or teacher to forward to the insurance company with your payment.

A copy of student's proof of medical insurance is attached.

Signature of Parent/Guardian

Date

PARENT PERMISSION

In consideration of the permission granted, we, the undersigned, hereby **RELEASE, DISCHARGE, AND HOLD HARMLESS** the Tulare Joint Union High School District from all liability arising out of or in connection with the identified athletic sport/activity. The release and discharge of the Tulare Joint Union High School District from all liability includes any defect or alleged negligence attributed to the Tulare Joint Union High School District or any of its coaches, agents, instructors, teachers or any assistants supervising or instructing in the athletic sport/activity.

(_____) (To be initialed by the student and/or parent or guardian)

I, _____, being the parent/legal guardian of _____ (student), have read the above release. I understand and agree to its terms. I understand that all sports can involve **MANY RISKS OF INJURY** including, but not limited to, those risks outlined above.

In the event of an accident, or sudden illness, the school district has my permission to render whatever emergency medical treatment may be deemed necessary for the above-named student.

I am signing this document on my own behalf, as well as on behalf of my student athlete.

Signature of Parent/Guardian

Date