

Student's name \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

In order for this form to be accepted, this form must be completed in BLACK INK.

Year/Month/Day

Office Use Only _____
Date Received _____
Fall _____
Winter _____
Spring _____

**FOUR PARENT SIGNATURES (IN BOXES LIKE THIS ONE) ARE REQUIRED!**

**MEDICAL HISTORY (to be completed by parent)**

RECORD OF ILLNESS	RECORD OF SYMPTOMS	INJURIES
Check those you have had, past or present <input type="checkbox"/> appendicitis <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> kidney/bladder <input type="checkbox"/> heart disease <input type="checkbox"/> hernia/rupture <input type="checkbox"/> loss of body part <input type="checkbox"/> convulsions <input type="checkbox"/> epilepsy <input type="checkbox"/> tonsillitis <input type="checkbox"/> surgery/operation (list)  <input type="checkbox"/> allergies (list)	Check those you have had, present or past <input type="checkbox"/> headaches <input type="checkbox"/> heart murmur <input type="checkbox"/> high blood pressure <input type="checkbox"/> easy bruising <input type="checkbox"/> blackouts/fainting spells <input type="checkbox"/> shortness of breath <input type="checkbox"/> emotional problems <input type="checkbox"/> nose bleeds <input type="checkbox"/> chest pains <input type="checkbox"/> stomach pains If you checked any of the above, please explain	Have you ever had any injuries? If yes, please give year and brief description:   Family History: yes ___no___ Unexpected death in a relative due to heart disease before age 50 yes ___no___ Disability from heart disease in a relative before age 50 yes ___no___ Cardiomyopathy, Long QT syndrome, Marfan or Arrhythmia

EYES When competing, do you wear glasses? \_\_\_ Contacts? \_\_\_

MEDICATIONS Are you taking any medication? \_\_\_yes \_\_\_no If yes, please list all medications taken regularly:

(PLEASE USE BLACK INK)  
SIGNATURE OF PARENT:

DATE:

**PHYSICAL EXAMINATION (to be completed by physician)**

WEIGHT \_\_\_\_ HEIGHT \_\_\_\_ PULSE \_\_\_\_ BP \_\_\_\_/\_\_\_\_ VISION \_\_\_\_/\_\_\_\_ CORRECTED \_\_\_yes \_\_\_no

NORMAL		NOT NORMAL	DESCRIPTION	NORMAL		NOT NORMAL	DESCRIPTION
	head				heart - up		
	eyes				heart - down		
	nose				abdomen		
	mouth				genitalia		
	neck				extremities		
	back				neurological		
	ears				Marfan		
	lungs				fem pulses		

PHYSICIAN COMMENT ON HISTORY AND PHYSICAL:

RECOMMENDATIONS \_\_\_unlimited participation \_\_\_limited participation \_\_\_no athletic participation

I hereby certify that \_\_\_\_\_ was examined by me on \_\_\_\_\_ and at that time no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in sports.

PHYSICIAN'S SIGNATURE:

DATE:

**ATHLETIC INSURANCE REQUIREMENTS**

California Education Code requires all athletes to have insurance. The specific requirements are outlined in paragraph two below. Paragraph three specifies that existing equivalent benefits may be substituted. (If you have medical insurance which meets the requirements of paragraph 2, please fill in the company name and policy number in LEFT BOX of the table (ATHLETIC INSURANCE IN-FORCE) below. Otherwise (or if you desire to purchase the excess coverage insurance) please fill in the RIGHT BOX ("I have..." of the table (ATHLETIC INSURANCE IN-FORCE) below. California Education Code section 32221 requires public schools to make available for each member of an athletic team insurance protection for medical and hospital expenses resulting from accidental bodily injuries in one of the following amounts:  
 1-A group or individual medical plan with accidental benefits of at least two hundred dollars (\$200.00) for each occurrence and major medical coverage of at least ten thousand dollars (\$10,000.00) with no more than one hundred dollars (\$100.00) deductible and no less than 80 percent payable upon occurrence.  
 2-Group or individual medical plans which are certified by the Insurance Commissioner to be equivalent to the required coverage of at least one thousand five hundred dollars (\$1,500.00).  
 3-At least one thousand five hundred dollars (\$1,500.00) for all such medical and hospital expenses.  
 The insurance required by Section 32221 shall not be required for any individual team member or student who has such insurance or a reasonable equivalent of health benefits coverage provided for the student in any other way or manner, including, but not limited to purchase by student or parent/guardian, by the student, or by the student's parent or guardian.

## ATHLETIC INSURANCE IN-FORCE

Athlete's name (in black ink) \_\_\_\_\_ Emergency phone numbers (in black ink) \_\_\_\_\_

<b>EXISTING MEDICAL INSURANCE</b> I have health or accident insurance for my son or daughter which meets the requirements of California law. I have listed the company name and policy or group number below: Company name (black ink) _____ Policy or group number _____	<b>OR</b>	<b>INITIAL FOR COVERAGE YOU HAVE PURCHASED</b> I have purchased Myers-Stevens & Co. coverage as indicated below in order to meet requirements of California law. I have initialed the purchased plan(s) that covers: only tackle football _____ (parent initials) all sports other than football _____ (parent initials) Policy Number _____
<p>I will promptly notify the school if insurance coverage no longer applies to my son or daughter. I hereby give my consent for the above named student to compete in interscholastic sports. I authorize the student to go with and be supervised by a representative of the school on any trips. In case this student becomes ill or is injured, you are authorized to have the student treated and I authorize the medical agency to render treatment.</p>		
<b>(PLEASE USE BLACK INK)</b> <b>SIGNATURE OF PARENT:</b> _____	<b>DATE:</b> _____	

This form is to be copied and carried in coach's medical kit.