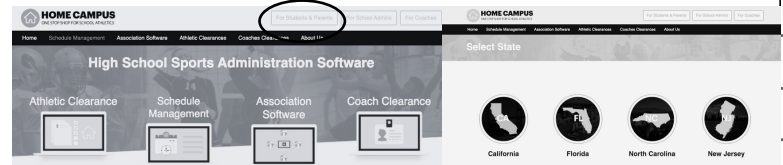


Athletic Clearance Instructions

- 1 VISIT HOMECAMPUS.COM
CLICK FOR PARENTS & STUDENTS
SELECT STATE**



Return Users

Log into existing account used in previous School Year.

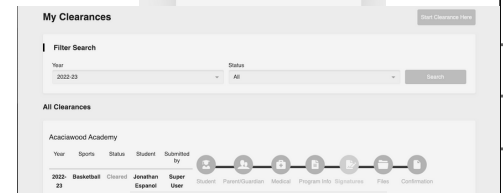
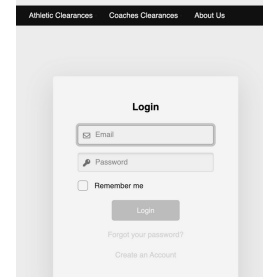
New Users

Create an account. Please register with a valid PARENT/GUARDIAN email address as the username and generate a password.

- 2 SELECT START CLEARANCE HERE**

Type in School & Confirm School Address
Select Year
Add Sports

Participating in multiple sports? Use Add New Sport button.



- 3 COMPLETE ALL REQUIRED FIELDS**

Student Information, Parent/Guardian Information, Medical History, Signature Forms, and upload any File(s).

Student Info & Parent Guardian Info

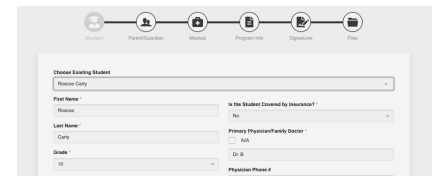
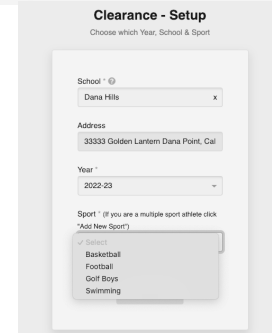
Type in Student & Parent/Guardian Information. This information will be saved for future clearances. Utilize the drop down menu to autofill information for subsequent clearances.

Signatures

Sign required documents by typing in an EXACT match of what is on the Student & Parent/Guardian page.

Files

Drag & drop or browse from your computer to add a file. Select Choose Existing File to search for a previously uploaded file.



- 4 CONFIRMATION MESSAGE**

Your clearance is ready for review by your school once you have reached the CONFIRMATION MESSAGE page.



**THE STUDENT IS NOT CLEARED YET!
THE SCHOOL MUST REVIEW AND CLEAR THE STUDENT. AN EMAIL NOTIFICATION WILL BE SENT ONCE THE SCHOOL HAS REVIEWED AND CLEARED THE STUDENT FOR PARTICIPATION.**

Athletic Clearance – Required Documents

1. **Confirmation Message from homecampus.com signed and dated (example below) *MUST BE SIGNED AND SUBMITTED TO ATHLETICS OFFICE IN ORDER TO BE CLEARED (Please either email to jtnguyen@nmusd.us , or bring to Athletics Office)**
2. **Preparticipation Exam Form signed and stamped by a physician – (upload to homecampus) *Physicals are good for one year after your exam date – please make sure it is dated and signed by the physician.**
3. **Current medical insurance card (upload to homecampus) *Medical insurance is required to participate in athletics. If you currently do not have medical insurance and would like to purchase, please see the Athletics Office for options.**

If you cannot upload your physical and insurance card, you may turn it in with your signed Confirmation/Consent Page to the Athletics Office

Confirmation Message

John Doe
Newport Harbor | Baseball | 2022-23

Dear [REDACTED]

John Doe's Athletic Clearance to participate in Baseball was submitted to Newport Harbor for review.

This does not mean that John Doe has been cleared to participate in athletics/activities at Newport Harbor. An email will be sent notifying you of any updates regarding your clearance status. Please contact the Newport Harbor Athletic Department with any questions regarding the status of your clearance.

By signing below, you confirm that all digital signatures and uploads submitted via the Athletic Clearance process have been completed by the Student and Parent/Guardian on record.

Thank you,
Newport Harbor Athletic Department

Student Signature

Date

Parent Signature

Date

EXAMPLE

HIGH SCHOOL ATHLETIC PRE-PARTICIPATION EXAM FORM **Circle One:** CDMHS CMHS EHS NHHS

Name: _____ Grade: _____ M/F
 (PRINT LEGIBLY) Last First Middle or Nickname (In Fall) Circle
 Birthdate: _____ Student ID #: _____ SPORT: _____ Fall _____ Winter _____ Spring

Section A: REQUIRED HEALTH HISTORY TO BE COMPLETED BY PARENT OR GUARDIAN

Has your child: ↓ If you answer "YES" to any questions, please explain below ↓

1.	Had a medical illness or injury that has disqualified him/her from athletic participation?	YES	NO
2.	Ever been hospitalized or undergone any surgical operations(s)?	YES	NO
3.	Had an ongoing chronic or serious illness (such as diabetes, kidney problems, seizures or asthma)?	YES	NO
4.	Ever taken any supplements or vitamins to help gain/lose weight or improve athletic performance?	YES	NO
5.	Ever passed out during/after exercise or become ill from exercising?	YES	NO
6.	Ever tired earlier than expected during exercise or complained of extreme fatigue?	YES	NO
7.	Ever had chest pain or unusual/irregular heartbeats during or after exercise?	YES	NO
8.	Had any history of heart problems, heart murmur, high blood pressure or high cholesterol?	YES	NO
9.	Had any family member or relative die before the age of 50 or die of heart-related problems?	YES	NO
10.	Had any family history of specific heart issues? If "YES," check all that apply: <input type="checkbox"/> Hypertrophic Cardiomyopathy <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Marfan's Syndrome <input type="checkbox"/> Long QT Syndrome	YES	NO
11.	Had any history of concussion, head injury, loss of memory or being unconscious?	YES	NO
12.	Had any history of seizures, convulsions or fainting episodes?	YES	NO
13.	Had frequent or severe headaches?	YES	NO
14.	Ever had a "stinger," "burner," or pinched nerve (numbness or tingling down an extremity)?	YES	NO
15.	Had any problems with vision that require glasses, contacts, or protective eyewear?	YES	NO
16.	Had special protective or corrective equipment/devices that are not usually used for sports? Examples: knee brace, neck roll, foot orthotics, retainer for teeth, hearing aids?	YES	NO
17.	Been diagnosed with a contagious skin condition within the past month?	YES	NO
18.	Ever broken/fractured any bones or dislocated any joints?	YES	NO
19.	Had any recurring problems with pain or swelling in back, muscles, tendons, bones or joints?	YES	NO
20.	Is your child currently under the care of a physician for any medical, orthopedic or emotional concerns?	YES	NO
21.	Had any history of asthma, allergies to foods, medicines, or stinging insects? If "YES," what medications are used? Is Epi-Pen needed?	YES	NO
22.	Does your child require any special health procedure(s) during the regular school day or during athletics?	YES	NO
23.	Is your child currently taking any prescription or "over-the-counter" medications or using an inhaler or Epi-Pen? If "YES" Please List All Medication: _____ Dose: _____ Frequency: _____ Medication: _____ Dose: _____ Frequency: _____	YES	NO
24.	Does your child have a history of having COVID-19? Date: _____	YES	NO
25.	Has your child received the COVID-19 vaccine? 1 st Dose Date: _____ 2 nd Dose Date: _____ Booster Dose Date (s): _____	YES	NO

If you have answered "YES" to any of the above questions, please explain:

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

Parent/Guardian Signature: _____ **Date:** _____

Section B: PHYSICAL EXAM REQUIRED FOR ALL ATHLETES: To be completed by HEALTHCARE PROVIDER

General:	Normal	Chest/Lungs	Normal	Visual acuity (Distance):	Right: /	Left: /
Eyes, ears, nose, throat		Neck		<input type="checkbox"/> Corrected	<input type="checkbox"/> Uncorrected	
Cardiovascular		Abdomen		Height:	Blood pressure:	
Femoral pulses		Skin		Weight:	Pulse:	
Musculoskeletal:	Normal	Normal	Normal	Discussion Points: Mental Health	Nutrition/Supplements	
Neck/Shoulder		Hips/Thighs	Arms/Hands	Stressed or under a lot of pressure	Supplements/Steroids	
Spine		Knees	Ankles/Feet	Sad/Hopeless/Depressed/Anxious	Eating Habits	

COMMENTS:

Recommendation: Full activity-No restrictions Activity with restrictions (explain below) No contact sports No participation Other

Please explain restrictions: _____

Examining Healthcare Provider (please print): _____
MD/DO/NP/PA ONLY

Signature: _____

DATE OF EXAM: _____ **Phone:** _____

Healthcare Provider Office Stamp:

Required

****NOT VALID WITHOUT STAMP****

NOT ACCEPTED WITHOUT DATE