CAPISTRANO UNIFIED SCHOOL DISTRICT

2025-26 Physical Clearance Form

SPORTS: (fall)		(winter)		(spring)	
Name		Grade in 2025-26	Male	Female	Date of birth //
Address					
		Work phone			
		Work phone			
		Phone			
***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 HISTOR	XY: TO BE COMPLE	TED BY PARENT	BEFORE DOCTOR	R EXAM
Any past	or present:	Yes No			Yes No
	s with vision		Surgeries		
Hed Problems	Eyeglasses		Dental problems		
Problems	Contacts s with hearing		<i>Braces</i> False teeth		
1 topichis	Hearing aid.	<u> </u>	Painful joints		
Blacking Unconsci	out or fainting ousness		Broken bones Body part,da	te	
Convulsi			Knee or ankle problems		
seizures Heart pro	oblems		Require supp Need for medication	oort/brace	
			Nama		
Rheumat	ic fever		Menstruation prob	lems	
	disorders gar problems		Hernias Asthma		
	Hypoglycemia			ASPECTS THE DOCTOR OULD BE AWARE OF:	
Allergies-			AND SCHOOL SHO	JULD BE AWARE OF:	
Bee or in Hospitali	sect stings zations				
Any histo	ory of chest pain with exercise	,			
Any history of "racing" heart or skipped beats?					<u> </u>
Do you experience passing out, near passing out or unexpected tiredness during exercise? Any family history of sudden cardiac death in a family 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 mononucle				uma.	<u> </u>
Any history of the following: absence of one kidney?					
• •	y of blindness in one eye?				
Any curr	ent active skin infection?				
PHYSICAL EXA	M: DATE	НЕІСНТ		WEIGHT	
PULSE:	RESTING	AFTER ACTIVITY		_B.P	
EYES	THROAT		ABDOMEN	OR	ТНОРЕДІС
EARS		GLANDS	HERNIA	SK	IN
TEETH	THYROII		POSTURE	ОТ	HER
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		**Phy	sician's Office Stamp**
Signature		Phone			

CAPISTRANO UNIFIED SCHOOL DISTRICT ATHLETIC INSURANCE VERIFICATION

Education Code Section 32221.5. Under state law, school districts are required to ensure that all members of school athletic teams have accidental bodily injury insurance providing at least \$1500 of scheduled medical/hospital benefits. 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 sponsored health insurance programs. Information about these programs may be obtained by calling: 1(800)281-9799.

- If you have at least \$1500, accidental bodily injury insurance, please upload your medical insurance card directly to www.athleticclearance.com.
- If you do not have accidentally bodily injury benefits for your son or daughter, you can purchase a medical and/or dental insurance plan through Myers-Stevens & Toohey. Sign up at www.myers-stevens.com. Proof of subscription to the appropriate insurance plan will need to be uploaded to www.athleticclearance.com.

Available plans include:

- o Interscholastic Tackle Football (Grades 9-12)
- o *Full Time (24/7) Accident Plan
- *School Time Accident Plan
- o Dental Plan
- o (Note: Full Time and School Time Accident Plans include all interscholastic sports except tackle football)