

# **ATHLETIC CLEARANCE DAY 2018-19**

@ Newport Orthopedic Institute  
22 Corporate Plaza Drive  
Newport Beach, CA 92660

**WEDNESDAY, JUNE 6, 2018 - BOYS ONLY (5:30-7:30 PM)**

**THURSDAY, JUNE 7, 2018 - GIRLS ONLY (5:30-7:30 PM)**

**PLEASE DO NOT ARRIVE LATER THAN 6:30 PM**

**BUS WILL BE AVAILABLE TO PICK UP STUDENT ATHLETES AT WHITTER ELEMENTARY SCHOOL AT 5,6PM, AT NHHS @ 5:15,6:15PM AND WILL RETURN TO BOTH LOCATIONS WHEN ALL PARTICIPANTS HAVE COMPLETED PHYSICALS**

Every athlete in every sport MUST have a completed clearance packet on file to participate in any high school athletic practice or game. Newport Harbor Athletics will be conducting physicals with registered medical doctors and nurses at Newport Orthopedics Institute. We are requesting a voluntary contribution of \$35.00. We will be accepting cash, check, or credit card. Checks should be payable to Newport Orthopedic Institute. Cash and checks will expedite the process and are the preferred payment. All proceeds, minus expenses will be divided between your student-athletes identified sport and the NHHS Athletic ASB account.

Clearance packets are available online @ <http://nhhs.nmusd.us> >Programs >Athletics, Drama, Music >Athletics >Athletic Clearance Forms OR you can pick up a packet in the Athletic Office. **Bring your completed clearance forms, required parent/guardian signatures, with a copy of your insurance card at your assigned time.** Please note: If you do not have a copy of your card, we will make copies for you. If you do not have insurance, our district offers Myers, Stevens & Toohey School-Time Accident plans to cover your student during the school year. For more information on this plan please visit [www.myers-stevens.com](http://www.myers-stevens.com).

If you have any questions, please call our Athletic department at 949-515-6308.

**We look forward to an exciting 2018-19 year in Newport Harbor Athletics!**

## **Go Sailors!**

\*Fall Sports: Boys Water Polo, Girls Volleyball, Boys & Girls Cross Country, Girls Tennis, Girls Field Hockey, Girls Golf

\*\*Winter Sports: Boys & Girls Basketball, Girls Water Polo, Boys & Girls Soccer, Boys & Girls Wrestling

\*\*\*Spring Sports: Baseball, Softball, Boys & Girls Lacrosse, Boys & Girls Track, Boys & Girls Swim, Boys Volleyball, Boys Golf, Boys Tennis

\*\*\*All Year: Cheer, Surf, Sailing

## **IMPACT CONCUSSION BASELINE TESTING**

**INCOMING 9<sup>TH</sup> GRADE STUDENT/ATHLETES WILL BE TESTED AT ENSIGN THROUGH P.E. CLASSES**

**11<sup>TH</sup> GRADE STUDENTS WILL BE TESTING IN EARLY FALL**



## Code of Ethics - Athletes

Athletics is an integral part of the school's total educational program. All school activities, curricular and extra-curricular, in the classroom and on the playing field, must be congruent with the school's stated goals and objectives established for the intellectual, physical, social and moral development of its students. It is within this context that the following Code of Ethics is presented.

As an athlete, I understand that it is my responsibility to:

1. Place academic achievement as the highest priority.
2. Show respect for teammates, opponents, officials and coaches.
3. Respect the integrity and judgment of game officials.
4. Exhibit fair play, sportsmanship and proper conduct on and off the playing field.
5. Maintain a high level of safety awareness.
6. Refrain from the use of profanity, vulgarity and other offensive language and gestures.
7. Adhere to the established rules and standards of the game to be played.
8. Respect all equipment and use it safely and appropriately.
9. Refrain from the use of alcohol, tobacco, illegal and non-prescriptive drugs, anabolic steroids or any substance to increase physical development or performance that is not approved by the United States Food and Drug Administration, Surgeon General of the United States or American Medical Association.
10. Know and follow all state, section and school athletic rules and regulations as they pertain to eligibility and sports participation.
11. Win with character, lose with dignity.

As a condition of membership in the CIF, all schools shall adopt policies prohibiting the use and abuse of androgenic/anabolic steroids. All member schools shall have participating students and their parents, legal guardian/caregiver agree that the athlete will not use steroids without the written prescription of a fully licensed physician (as recognized by the AMA) to treat a medical condition (Article 523).

By signing below, both the participating student athlete and the parents, legal guardian/caregiver hereby agree that the student shall not use androgenic/anabolic steroids without the written prescription of a fully licensed physician (as recognized by the AMA) to treat a medical condition. We recognize that under CIF Bylaw 202, there could be penalties for false or fraudulent information.

We also understand that the \_\_\_\_\_ (school/school district name) policy regarding the use of illegal drugs will be enforced for any violations of these rules.

\_\_\_\_\_  
Printed Name of Student Athlete

\_\_\_\_\_  
Signature of Student Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Caregiver

\_\_\_\_\_  
Date

A copy of this form must be kept on file in the athletic director's office at the local high school on an annual basis and the Principal's Statement of Compliance must be on file at the CIF Southern Section office.

Revised 7/12

### Consent for Treatment

I hereby authorize the Certified Athletic Trainers and sports medicine staff at Newport Harbor High School, acting on behalf of Newport Orthopedic Institute, to evaluate and treat any injury/illness that occurs as a result of my participation in athletics. This includes reasonable and necessary preventative care, treatment and rehabilitation for these injuries/illness.

I understand that I must refrain from practice while injured/ill, whether or not receiving medical care. When under medical care, I may not return to participation until I have been given permission by a Physician, PA-C, or Certified Athletic Trainer. This may occur during or at the conclusion of medical treatment.

I understand and agree that if I experience an injury/illness or change to my health status, it is my responsibility to inform my Head Coach and the Certified Athletic Trainer. I also agree to adhere to the established injury management guidelines, including rehabilitation and reassessment before I am released to return to full participation.

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Athlete's Name

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Signature

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Parent/Guardian (if student athlete is under 18)

### Authorization to Disclose Private Health Information

I grant permission to Newport Orthopedic Institute, the Certified Athletic Trainers, sports medicine staff, and other Newport-Mesa Unified School District personnel and authorized volunteers, including at Newport Harbor High School, to disclose my Personal Health Information (written and/or verbal), when requested to do so, for the purpose of health care treatment, or for any other purpose which is required by law.

Personal Health Information includes, but is not limited to: information involving the nature and treatment of an injury/illness, medical history, insurance coverage and copies of all medical records. This information will be released ONLY for the purposes of further treatment (referrals to specialists or other health care providers), or disclosure of participation status to Newport-Mesa Unified School District personnel and authorized volunteers, including your team's coaches, for your health and safety.

In order to maintain continuity of care and provide participation status updates to athletic department personnel, I hereby authorize the Certified Athletic Trainers to disclose injuries/illness contained in my student-athlete medical file, including medical file, including medical condition(s), treatment and rehabilitation status, and restrictions to the following entities:

- A) Physicians: Newport Orthopedic Institute
- B) Newport-Mesa Unified School District staff and authorized volunteers who have a legitimate educational interest in the information (34 C.F.R. § 99.31; Education Code § 49076.)

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Athlete's Name

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Signature

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Parent/Guardian (if student athlete is under 18)



# Newport Harbor High School

NEWPORT-MESA UNIFIED SCHOOL DISTRICT

## Student Authorization/Consent for Disclosure of Protected Health Information

I/we, \_\_\_\_\_, parent(s)/guardian(s) of \_\_\_\_\_  
Name of Parent(s)/Guardian(s) Name of Student

hereby authorize Newport Harbor High School and its administrators, athletic trainers and health care personnel to disclose my protected health information including, without limitation, any information regarding any injury, illness, treatment or participation related to or affecting my training for and participation in athletics to the District, and its designated employees, agents and/or contractors. I/we further authorize the District to disclose, and/or use, such information as provided herein.

I/we understand that my participation and protected health information, including, without limitation, conditions, injuries, or illnesses resulting from or affecting training for or participation in athletics, may be disclosed to, and/or used by, the District, and any third party expressly authorized by the District to receive such information for the purposes described in this paragraph. The information provides the District, athletic leagues using District facilities, and individual schools, with injury, relevant conditions and illnesses, and participation data that identify individual students' fitness to participate in (a) specific athletic program(s) and, if applicable, any special conditions related to such participation.

I/we understand that this protected health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I/we understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I/we provide the consent or authorization requested for this disclosure. I/we also understand that I/we am/are not required to sign this authorization/consent in order for my/our child to be eligible for participation in District athletics.

I/we understand that while HIPAA regulations may not apply to District use or disclosure of my/our child's injury/illness information, the District is committed to protecting his/her privacy

This authorization/consent for transfer of protected health information expires at the end of the school year following from the date of my signature below, but I/we have the right to revoke it in writing at any time by sending written notification to the District. I/we understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

The undersigned hereby acknowledges that I/we knowingly and voluntarily assume(s) all risks of to his/her child/ward or we/him/herself, as stated, and expressly acknowledges my/our intention, by executing this instrument, to exempt and relieve the District, its officers, agents, and employees, from any liability for personal injury, bodily injury, property damage or wrongful death that may arise out of or in any way be connected with this consent. I/we have read and understand the foregoing and have voluntarily signed this consent. I/we am/are aware of the potential risks involved in this consent and I/we am/are fully aware of the legal consequences of signing this instrument.

(Check Box) - I want my student/athlete to participate in Baseline Impact Concussion Testing.

\_\_\_\_\_  
Printed Name of Student/Participant

\_\_\_\_\_  
Student/Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Parent/Guardian Signature(s)

\_\_\_\_\_  
Date

NEWPORT-MESA UNIFIED SCHOOL DISTRICT  
HIGH SCHOOL ACTIVITIES FORM

(A new form must be on file in the Athletic Office each school year that the student participates in a sport.)

List of Sport(s) you intend to try out for: \_\_\_\_\_  
\_\_\_\_\_

Date Received in Athletic Office: \_\_\_\_\_

GPA check:  
(for office use only)

Student's Name: \_\_\_\_\_ M / F 9 10 11 12 Cell Phone: \_\_\_\_\_  
Last First Sex Grade Alternate Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Parent Email: \_\_\_\_\_

School attended last year: \_\_\_\_\_

Student Email: \_\_\_\_\_

1. PARENT'S OR GUARDIAN'S PERMISSION:

I hereby give my consent for the above-named student to compete in the Newport-Mesa Unified School District's approved activity program such as sports, marching band, drill team, etc., and travel with the school representative on necessary school trips. I realize that there is a risk of serious injury from participation in school sports and related activities.

It is understood that the school district, the student body, and/or any of the employees are not financially responsible in case of accident or injury.

2. CONSENT FOR EMERGENCY TREATMENT:

I hereby give permission to a physician to administer emergency treatment. The team physician, trainer or coach may apply first aid treatment until emergency assistance arrives. \_\_\_\_yes \_\_\_\_no  
In Case of Emergency, if Parent/Guardian cannot be contacted, please contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

List any allergies/medications:  
\_\_\_\_\_

3. INSURANCE CERTIFICATION:

I hereby certify that the above-named student is covered by accident insurance which provides protection for accidental bodily injury as required by Education Code Sections 32220-32221 for participation in approved school activities during the 2018 to 2019 school year. I understand that the above-named student will be permitted to participate in the District's activity program only upon my representation that insurance coverage as described in Section 3A. or 3B. is in effect for the present school year. *If there is a change in medical insurance, it is the parent/guardian responsibility to notify the school.*

A. OR B. Must be completed for clearance so the student athlete may participate.

3A. Medical Insurance Plan (Required to attach copy of insurance card)

Name of Medical Insurance Company and Policy or Group Number: \_\_\_\_\_

3B. District-offered insurance plan must be purchased by parent/guardian, if the student does not have medical insurance.

- School Time Plan (DOES NOT INCLUDE TACKLE FOOTBALL)  
 Full Time 24-Hour Plan (DOES NOT INCLUDE TACKLE FOOTBALL)  
 Tackle Football Plan (Includes TACKLE FOOTBALL ONLY). If playing another sport after football, you must buy another plan.

4. I have read the Ed Code requirements for insurance stated on the back of this form.  
5. We agree to be responsible for the **safe return of all equipment** issued by the school to the above-named student.  
6. Student promises to abide by the California Interscholastic Federation/Southern Section, League, and school rules of eligibility.

The undersigned agrees to numbers 1 - 6 above:

Signature of Student: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

## INSURANCE FOR ATHLETIC TEAMS

### Education Code Section 32220. Definitions

As used in this chapter:

- (a) "Education Institution" means a school district
- (b) "Governing Board" means the governing board of a school district
- (c) "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.

Organized rooting sections, student body members who are spectators, and other spectators, students, who are not actually participating in the conduct of the athletic event, are not members of an athletic team. Participants in a play day or field day activity occurring occasionally during a school year, in which students of one or more particular grade levels from two or more schools of a school district or community college district participate in athletic contests, are not members of an athletic team. Nothing in this section shall be construed as prohibiting a governing board from extending the applicability of the provisions of this article to any such persons, should the governing board elect so to do.

- (d) "Student body organization" means any student organization under supervision of the educational institution or its officers.

### Education Code Section 32221. Insurance; Amounts

The governing board of any education institution, except a school district or community college district of any kind or class and Department of Education special schools as defined in Sections 59000, 59100, and 59200, shall provide for each member of an athletic team insurance protection for medical and hospital expenses resulting from accidental bodily injuries in an amount of at least five thousand dollars (\$5,000) for all such services for each member of an athletic team, through group, blanket or individual policies of accident insurance from authorized insurers, or through a benefit and relief association described in subparagraph (1) of subdivision (c) of Section 10493 of the Insurance Code. Such coverage shall be for the injury to members of athletic teams arising while such members are engaged in or are preparing for an athletic event promoted under the sponsorship or arrangements of the educational institution or a student body organization thereof or 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 school or other place of instruction and the place of the athletic event; .....

The governing board of each school district or community college district of any kind or class and the Department of Education special schools as defined in Sections 59000, 59100 and 59200 shall provide 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:

- (a) A group or individual medical plan with accidental benefits of at least two hundred dollars (\$200) for each occurrence and major medical coverage of at least ten thousand dollars (\$10,000), with no more than one hundred dollars (\$100) deductible and no less than eighty percent (80%) payable for each occurrence.
- (b) 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).
- (c) At least one thousand five hundred dollars (\$1,500) for all such medical and hospital expenses.

Insurance protection in any of the above amounts shall be provided through group, blanket or individual policies of accident insurance from authorized insurers or through a benefit and relief association described in subparagraph (1) of subdivision (c) of Section 10493 of the Insurance Code. Such coverage shall be for the injury to members of athletic teams arising while such members are engaged in or are preparing for an athletic event promoted under the sponsorship or arrangements of the educational institution or a student body organization thereof or while such members are being transported by or under the sponsorship or arrangements of the school districts or community college districts or a student body organization thereof to or from school or other place of instruction and the place of the athletic event. Minimum medical benefits under any insurance required by this paragraph shall be equivalent to the three dollars and fifty cents (\$3.50) conversion factor as applied to the unit values contained in the minimum fee schedule adopted by the Division of Industrial Accidents of the State of California, effective October 1, 1966.

The governing boards of the various school districts or community college districts and the Department of Education special schools shall require that each member of an athletic team have insurance protection as prescribed by this section, with the costs of such insurance protection to be paid either out of the funds of the district, the funds of the student body, or by any other persons on behalf of, the individual team members or students covered by such insurance. In the event that the governing board of a school district or community college district should determine that a member of an athletic team or the parents, guardians or other person having charge or control of a member of an athletic team are financially unable to pay the costs of such insurance protection, then the governing board shall require the costs of such protection to be paid either out of funds of the district or funds of the student body.

The insurance required by this article shall be issued by an admitted insurer, or through a benefit and relief association described in subparagraph (1) of subdivision (c) of Section 10493 of the Insurance Code.

The insurance otherwise required by this section 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 him in any other way or manner, including, but not limited to, purchase by himself or by his parent or guardian.

## Child Health and Disability Prevention (CHDP) Program Preparticipation Physical Evaluation History Form

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Grade: \_\_\_\_\_ School: \_\_\_\_\_ Sport(s): \_\_\_\_\_

*This form should be filed in the patient's medical chart.*

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

**Allergies:** Do you have any allergies?  Yes  No If yes, please identify specific allergies below:  
 Medicines: \_\_\_\_\_  Pollens: \_\_\_\_\_  Foods: \_\_\_\_\_  Stinging Insects: \_\_\_\_\_

*This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before seeing the health care provider.  
Explain Yes answers below. Circle questions that 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 <input type="checkbox"/> Other: _____		
3. Have you ever spent the night in a 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"/> Kawasaki Disease <input type="checkbox"/> A Heart Infection <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol 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?		
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 (for example, tear, sprain, or tendonitis) that caused you to miss a practice or game?		
18. Have you 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 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 that 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 food?		
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	Yes	No
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?		
<b>Explain "yes" answers here:</b>		

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

Signature of athlete: \_\_\_\_\_ Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Child Health and Disability Prevention (CHDP) Program  
Physical Examination Form for Preparticipation**

The section below is to be completed by physician or provider after history and consent forms are completed.

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ %BMI (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )  
 Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal Unequal

**EMERGENCY INFORMATION**

Allergies: \_\_\_\_\_  
 Other Information: \_\_\_\_\_

<b>MEDICAL</b>	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 <sup>1</sup> ● Murmurs (auscultation standing, supine, +/- Valsalva) ● Location of point of maximal impulse (PMI)		
Pulses ● Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) <sup>2</sup>		
Skin ● HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic <sup>3</sup>		
<b>MUSCULOSKELETAL</b>		
Neck		
Back		
Shoulder/ Arm		
Elbow/ Forearm		
Wrist/ Hand/ Fingers		
Hip/ Thigh		
Knee		
Leg/ Ankle		
Foot/ Toes		
Functional ● Duck-walk, single leg hop		

<sup>1</sup> Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
<sup>2</sup> Consider GU exam if in private setting. Having third party present is recommended.  
<sup>3</sup> Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

**Clearance**

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 evaluated the above named student and completed the preparticipation physical evaluation. The athlete does not present apparent contraindications to practice, tryout, 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 parent. 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/ Provider: (print/ type/ stamp) \_\_\_\_\_ (MD, DO, NP, or PA) Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician/ Provider: \_\_\_\_\_