

PLACENTIA-YORBA LINDA UNIFIED SCHOOL DISTRICT

1301 E. Orangethorpe Ave., Placentia, CA 92870

ATHLETIC/AUXILIARY INSURANCE CERTIFICATION FORM

Student's Name: _____ School: _____

If your student plans to participate in interscholastic athletic and/or auxiliary events (including activities of marching bands, drill teams, dance teams, cheerleaders, color guard, banner carriers, baton twirlers, mascots, and team managers), it is legally required that you either:

- (1) Furnish the school with an affidavit certifying that your child is covered by insurance that provides at least the equivalent protection required by law as described below; or
- (2) Purchase the student accident insurance that is available from Myers-Stevens & Toohey & Co., Inc. Student Accident Plan. For those wishing to purchase student accident insurance through Myers-Stevens & Toohey & Co., Inc., applications and brochures are available in your athletic clearance packet and in the Student Activities Office.

DECLARATION OF PARENT OR GUARDIAN

Please check as applicable.

☐	I hereby certify, under penalty of perjury, that the above-named pupil is covered by valid insurance that provides the following: 1) Insurance protection for medical and hospital expenses resulting from accidental bodily injuries in one of the following amounts: (Ed. Code 32221) 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 medical and hospital expenses. 2) I hereby agree that this policy shall not be cancelable without at least 10 days prior written notice to the district. I will maintain the above coverage during the current school year or will immediately notify the school if the coverage terminates or does not meet the above requirements. 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, such as California Interscholastic Protection Fund, for the death or 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 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 Department of Industrial Relations of the State of California, effective October 1, 1966. (Ref. Ed. Code 32221) Insurance Company _____ Policy/Group No. _____ Expiration Date of Policy _____ Please attach a copy of Insurance Card (front and back) or Policy.
☐	I will purchase the Myers-Stevens & Toohey & Co., Inc. Student Accident policy for all athletics and activities except tackle football.
☐	I will purchase the Myers-Stevens & Toohey & Co., Inc. Student Accident policy for tackle football.
☐	My student will not participate in any activity requiring insurance under Education Code Section 32220-32222 and I do not wish to purchase any insurance from Myers-Stevens & Toohey & Co., Inc. Student Accident Plan

Parent/Guardian Signature _____ Parent/Guardian Name – Please Print _____ Date _____

Home Phone: _____ Address: _____

Work Phone: _____ City _____ State _____ Zip _____

PLACENTIA-YORBA LINDA UNIFIED SCHOOL DISTRICT - SPORTS PRE-PARTICIPATION PHYSICAL

Name _____ Age _____ ☐ Male ☐ Female
 Date of Birth _____ Grade _____ School _____ School Year ☐ 20____ ☐ 20____ ☐ 20____

Check sport(s) of participation:

☐ Band ☐ Baseball ☐ Basketball ☐ Cheer ☐ Color Guard ☐ Cross-country ☐ Dance ☐ Diving ☐ Football ☐ Golf ☐ Lacrosse ☐ Song
☐ Tennis ☐ Soccer ☐ Softball ☐ Track/Field ☐ Swim ☐ Volleyball ☐ Water Polo ☐ Wrestling ☐ Other _____

PARENT - Please answer questions 1-21

Has the student/athlete ever:

YES NO

1. Been hospitalized overnight? Diagnosis		
2. Had any chronic illness? ☐ asthma ☐ diabetes ☐ frequent headaches ☐ bleeding disorder ☐ Other		
3. Recently taken medication including over-the-counter meds or inhalers? Medication:		
4. Had any allergies (medication, bee stings, etc) Allergy:		
5. Become dizzy or passed out during exercise?		
6. Developed chest pain, shortness of breath or wheezing?		
7. Become tired more quickly than peers during exercise?		
8. Been told that he/she has a heart murmur or heart disease?		
9. Skipped heart beats?		
10. Had anyone in the family develop heart disease or die from heart problems under age 40?		
11. Had a significant head injury or concussion?		
12. Passed out or had a seizure?		
13. Had more than one episode of burner/stinger (pain from neck into arm)?		
14. Had heat cramps or heat exhaustion?		
15. Had a broken/fractured, sprained, or dislocated body part? List body part(s) and date(s) of injury.		
16. Is the student/athlete missing an organ or limb? List body part(s) and date(s) of loss.		
17. Does student/athlete use special equipment? ☐ Pads ☐ Braces ☐ Orthotics ☐ Prostheses ☐ Other		
18. Does student/athlete have to gain or lose weight to meet the requirements of his/her sport(s)?		
19. Does student/athlete eat a healthy well balanced diet?		
20. For Females: Are menses (periods): ☐ regular/monthly ☐ irregular ☐ absent		
21. Last tetanus immunization:		

I hereby authorize the use and/or disclosure of my student/athlete's individual health information for the purpose of medical clearance for participation in the district's sports program. I understand that this authorization is voluntary.

Student's Signature _____

Date _____

Parent's Signature _____

Date _____

PHYSICAL EXAMINATION BY PHYSICIAN

Height _____ Weight _____ BP _____
 Pulse _____ Body Habitus _____

Visual Acuity:

Right eye 20/ _____ Left eye 20/ _____ Both eyes 20/ _____

Legend: / = within normal limits + = see comments x = omitted

General	/	+	x	General	/	+	x	Orthopedic	/	+	x	Orthopedic	/	+	x
Head				Heart				Cervical Spine/Back				Knees			
Eyes				Abdomen				Arms/Elbows/wrists/hands				Ankles/feet			
Ears/nose/throat				Genitalia/hernia				Hips				Flexibility			
Neck				Neurological											

Comments:

Discussion Items	Yes	No
Stretching emphasized		
Discussed fitness/ideal weight		
Discussed treatment of injuries		
Discussed prevention of sun/heat-related problems		
Discussed testicular cancer exams		

Medical Clearance * as appropriate for age and development	Yes	No
Full contact collision level		
Clearance deferred or no participation at this time because		

MD/DO/FNP:

State License Number:

Phone:

Address (Doctor's Stamp Required):

Date: