

**OAK PARK HIGH SCHOOL  
899 NORTH KANAN RD.  
OAK PARK, CA 91377  
ATHLETIC PHYSICAL ACTIVITY CERTIFICATE (rev 10.2013)**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Sport \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

**Parent or Guardian's Consent**

I hereby give my consent for the above-named student to compete in Oak Park High School's approved activity program (athletics, cheerleading etc.) and travel with the school representative(s) on authorized school trips. 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. Each parent may be assured, however, that prudent precaution will be taken to protect the student. The undersigned agrees to be responsible for the safe return of all equipment issued by the school to the above-named student. Failure will result in full replacement costs being collected for any and all such equipment not returned.

**Consent for Emergency Treatment**

I hereby give my permission to a physician to administer emergency treatment to the above-named student.

**Insurance Certification**

I hereby certify that the above-named student is covered by accident insurance, which provides protection for accidental bodily injury and for accidental death as required by Education Code Sections 32220-24 for participation in approved school activities during the present school year. Private insurance plans must provide the following minimum coverage:

1. 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 \$200 dollars for each occurrence and major medical coverage for at least \$10,000 with no more than \$100 deductible and no less than 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 \$1500.
  - c. At least \$1500 for all such medical and hospital expenses.
2. The insurance required is issued by an admitted insurer, or through a benefit and relief association described in subparagraph (A) of subdivision ( 3 ) of section 10493 of the insurance code.

**Private/Group Insurance Plan**

Name & Address of Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

I have fully read and understand all above items and affix my signature to certify name.

**SIGNATURE OF PARENT OR GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

**HEALTH HISTORY  
(To be filled out and signed by parent)**

Has your child, \_\_\_\_\_ ever had or now have:

Yes	No	(Check Each Item)	Yes	No	(Check Each Item)	Yes	No	(Check Each Item)
( )	( )	Allergy	( )	( )	Arthritis	( )	( )	Asthma
( )	( )	Chicken Pox	( )	( )	Concussion	( )	( )	Diabetes
( )	( )	Emotional Problems	( )	( )	Epilepsy	( )	( )	Fainting
( )	( )	Glasses/Contacts	( )	( )	Heart Murmur	( )	( )	Hepatitis
( )	( )	Kidney Trouble	( )	( )	Measles	( )	( )	Menstr. Cramps
( )	( )	Migraine Headaches	( )	( )	Mononucleosis	( )	( )	Mumps
( )	( )	Pneumonia	( )	( )	Polio	( )	( )	Rheumatic Fever
( )	( )	Sinus Trouble	( )	( )	Tuberculosis	( )	( )	Whooping Cough
( )	( )	Other	( )	( )	Other	( )	( )	Other

Operations \_\_\_\_\_ Nature \_\_\_\_\_ Year \_\_\_\_\_

Fractures \_\_\_\_\_ Nature \_\_\_\_\_ Year \_\_\_\_\_

Sprains/Dislocations \_\_\_\_\_ Nature \_\_\_\_\_ Year \_\_\_\_\_

If student has had prolonged absences from school, state when and why: \_\_\_\_\_

Allergic to food/medicine \_\_\_\_\_

Is student now under medical treatment? \_\_\_\_\_ Why \_\_\_\_\_

Sports from which student is to be excluded \_\_\_\_\_

Dates of last: Tetanus Booster \_\_\_\_\_ Chest X-ray \_\_\_\_\_ Smallpox Vac. \_\_\_\_\_

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### California Interscholastic Federation Physical Examination Summary

(To be filled out and signed by examining physician)

Ht. _____	Wt. _____	Eyes: L _____ R _____	Blood Pressure _____ / _____	Normal ( )
Eyes: Sclera _____			Corneas _____	( )
Ears: Canals _____			TM's _____	( )
Nose: Septum _____			Mucosa _____	( )
Throat: Tonsils _____			Teeth _____	( )
Cardiovascular: Murmur _____ ( )				
			Pulses _____ ( )	
Respiratory _____				( )
Abdomen: Organs _____			Masses _____	( )
Genitalia: Testes _____			Hernia _____	( )
			Urine _____	( )
Musculoskeletal _____				( )
Neurological: DTR's _____				( )
Strength & Coordination _____				( )

I hereby certify that I have on this date examined the above student and that I have found no medical reason to disqualify him/her from participating in supervised athletics **NOT CROSSED OUT BELOW.**

Baseball	Cross Country	Golf	Softball	Tennis	Volleyball
Basketball	Football	Soccer	Swimming	Track	Cheerleading/Dance

\_\_\_\_\_  
Name of Physician (please print) Date \_\_\_\_\_

\_\_\_\_\_  
Signature of examining physician

*Please note: Physicals done by school doctor at the annual school-wide physical date are not to replace your regular annual check-up with your primary-care physician.*