OAK PARK HIGH SCHOOL
899 NORTH KANAN RD.
OAK PARK, CA 91377
ATHLETIC PHYSICAL ACTIVITY CERTIFICATE

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 student CLEARED FOR ALL SPORTS

_____ Date _____
Name of Physician (please print)

_____ _____ CLEARED (_____) NOT CLEARED (_____) **
Signature of examining physician Date

**Comments/Further Evaluation:

_____ _____
Signature of re-evaluating physician Date CLEARED (____) NOT CLEARED (____)

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.

Revised 4/26/2018