2021-2022 Athletic Clearance

Parents, The Athletic Clearance process is an ANNUAL requirement for all students wishing to participate in CDM athletics. Fall sports need a clearance by July 30, 2021; Winter and Spring sports by August 16, 2021.

1. Get a Pre-Participation Exam and clearance from a medical doctor and have physical form signed (See below for Physical forms)
2. Go to www.AthleticClearance.com
3. New Students/Freshman: Create an account; have medical insurance card with you (Return athletes: Log-in to existing account)
4. Complete required information
5. Upload your physical, medical history and a copy of your medical insurance card
6. Print the Confirmation/Consent page after checking the boxes for each sport you will play; this is displayed just below the PRINT button
7. Parent/Guardian and Student sign the Confirmation/Consent page, email as a pdf or turn in at the Athletic Office
8. **The Confirmation/Consent form must be submitted to the Athletics Office in order to be cleared

(Please email to sdoyle@nmusd.us)

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1. www.AthleticClearance.com Create Account (only one per family)
2. Get clearance from a Medical Doctor

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: _____

MEDICAL	Normal	Abnormal Findings
Appearance • Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, hypermobility, MVP, aortic insufficiency)		
Eyes/ Ears/ Nose/ Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)*		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic*		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/ Arm		
Elbow/ Forearm		
Wrist/ Hand/ Fingers		
Hip/ Thigh		
Knee		
Leg/ Ankle		
Foot/ Toes		
Functional • Duck-walk, single leg hop		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or death.
†Consider eye exam for private setting. Having this party present is recommended.
‡Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Clearance

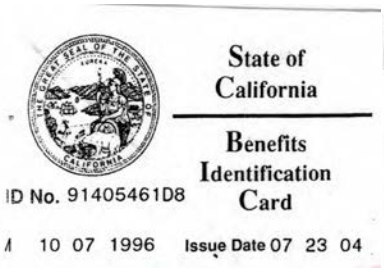
☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____
☐ Not cleared:
  ☐ Pending further evaluation
  ☐ For any sports
  ☐ For certain sports: _____
Reason/Recommendations: _____

I have evaluated the above named student and completed the preparticipation physical evaluation. The athlete does not present apparent contraindications to practice, hysol, 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).

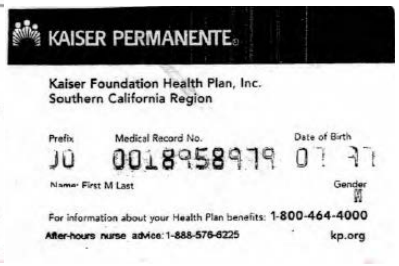
Name of Physician/ Provider: (Office stamp required) _____ (MD, DO, NP, or PA) Date: _____
Address: _____ Phone _____
Signature of Physician/ Provider: _____

3. Provide a copy of student athlete medical insurance card:

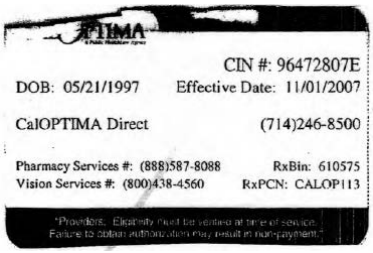
Examples:



State of California
Benefits Identification Card
ID No. 91405461D8
10 07 1996 Issue Date 07 23 04



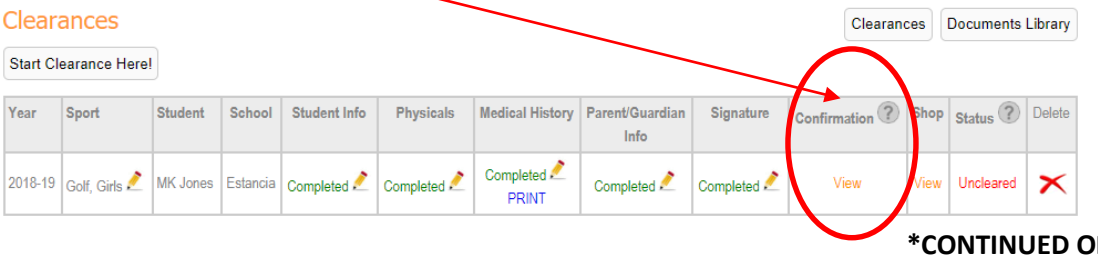
KAISER PERMANENTE
Kaiser Foundation Health Plan, Inc.
Southern California Region
Prefix Medical Record No. Date of Birth
JO 00189589?9 07 ??
Name First M Last Gender
For information about your Health Plan benefits: 1-800-464-4000
After-hours nurse advice: 1-888-576-6225 kp.org



CalOPTIMA
CIN #: 96472807E
DOB: 05/21/1997 Effective Date: 11/01/2007
CalOPTIMA Direct (714)246-8500
Pharmacy Services #: (888)587-8088 RxBin: 610575
Vision Services #: (800)438-4560 RxPCN: CALOP113
*Providers: Eligibility must be verified at time of service. Failure to obtain authorization may result in non-payment.

4. HOW TO FIND the Confirmation Message:

Click on the word View Print, sign and turn it at the Athletic Office



Clearances

Clearances | Documents Library

Start Clearance Here!

Year	Sport	Student	School	Student Info	Physicals	Medical History	Parent/Guardian Info	Signature	Confirmation	Shop	Status	Delete
2018-19	Golf, Girls	MK Jones	Estancia	Completed	Completed	Completed PRINT	Completed	Completed	View	View	Uncleared	✕

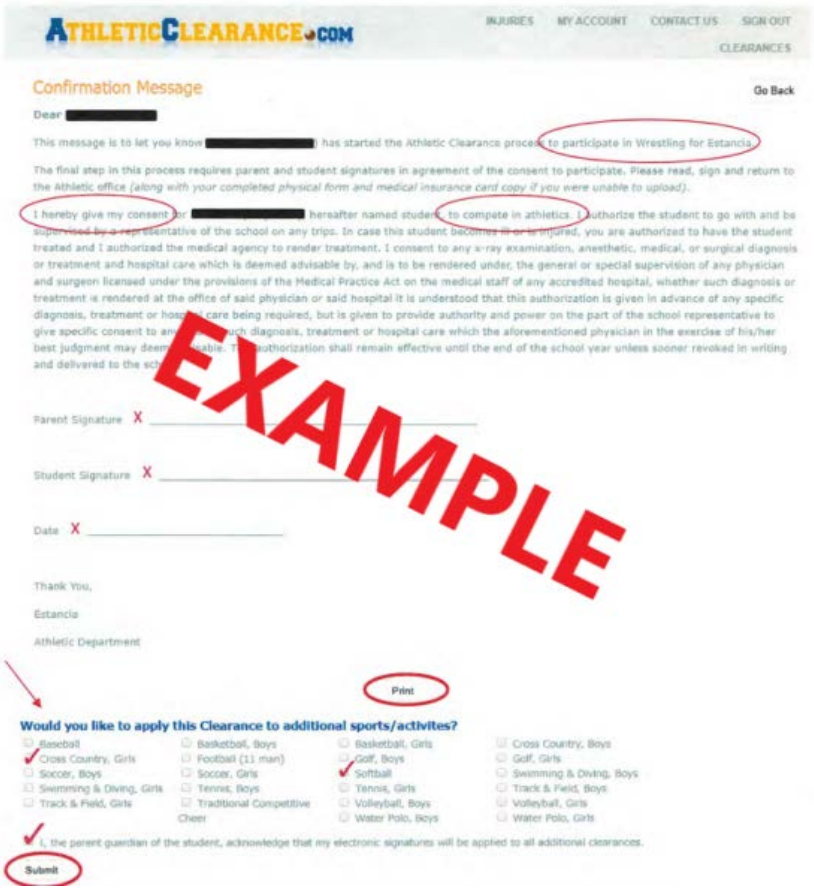
*CONTINUED ON BACK

CHECKLIST OF REQUIRED DOCUMENTS

1. **Confirmation Message from AthleticClearance.com signed and dated (example below) *MUST BE SUBMITTED TO ATHLETICS OFFICE IN ORDER TO BE CLEARED (Please email to sdoyle@nmusd.us)**

2. **Preparticipation Physical Evaluation Form signed by a physician (Both sides uploaded, see below)** *Physicals are good for one year after the exam date

3. **Current medical insurance card (uploaded**) *Medical insurance is required to participate in athletics. If you currently do not have medical insurance and would like to purchase, please see the Athletics Office for options.



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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ 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: ☐ Kawasaki Disease ☐ A Heart Infection ☐ High Blood Pressure ☐ A Heart Murmur ☐ 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 of 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?		

Explain "yes" answers here:

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: _____

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

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Name of Physician/ Provider: (print/ type/ stamp) _____ (MD, DO, NP, or PA) Date: _____

Address: _____ Phone: _____

Signature of Physician/ Provider: _____