

Adolfo Camarillo HS (805) 389-6407	Channel Islands HS (805) 385-2787	Hueneme HS (805) 385-2667	Oxnard HS (805) 278-2907	Pacifica HS (805) 278-5000	Rio Mesa HS (805) 278-5500
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**Oxnard Union High School District  
Insurance Requirement / Parent Authorization / Physician Certification Form  
Physical is Valid for a School Year**

Date \_\_\_\_\_ Sport(s) \_\_\_\_\_

Last Name		First Name		Initial	Grade	Date of Birth	Sex
Address				Phone Number			
Emergency Phone		Father's Work Phone		Mother's Work Phone			
Name of Family Physician			Telephone #		Student #		ASB Card #

**• Parent Authorization / Informed Consent / Assumption of Risk Section**

I understand and acknowledge that athletic activities, by their very nature, pose the potential risk of serious injuries/illnesses to the participant, which may include, but are not limited to: **sprains, fractured bones, unconsciousness, head/back injuries, paralysis, loss of eyesight, communicable diseases, and death.** I further understand that participation in athletics is voluntary. I hereby grant permission for the above-named student to participate in the interscholastic sports program of the school and to go with a representative of the school on *any* trips. Furthermore, I release the Oxnard Union High School District and its employees, agents, officers, and volunteers from any liability connected therewith, and I agree to assume all liability for potential risks associated with athletic participation. In the event that this pupil is injured, I grant permission for a school representative to have him/her treated. I also certify that above-named student is covered by insurance that meets the requirement of the California law (at least \$1,500 medical and hospital benefits). I agree to notify the school if any of the above coverage should change. Lastly, I have read and agree to follow the athletic code of conduct.

Athlete Signature \_\_\_\_\_ Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**• Annual Physical Examination Section**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_) Vision Corrected: Y / N Pupils Equal: Y / N

Area	Normal	Abnormal	Area	Normal	Abnormal	Area	Normal	Abnormal
Ears/Nose/ Throat			Heart			Orthopedic		
Thyroid			Lungs			Posture		
Lymph Glands			Abdomen			Reflexes		
Skin			Hernia			Muscular		

ABNORMAL HISTORY/FINDINGS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ REGULAR MEDICATIONS: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

CLEARED FOR ATHLETICS       NOT CLEARED –Reason: \_\_\_\_\_

Name of Physician/Medical Professional: \_\_\_\_\_ \*Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_ State License #: \_\_\_\_\_

\* The above-signed physician is NOT responsible for any ensuing medical problems or litigation. Form adapted from © 2005 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

**This form must be on file with the school of attendance for verification of eligibility prior to participation in any athletic event**

Please upload this form with Doctor/Medical Practitioner signature to <https://www.athleticclearance.com/> and complete all necessary information. The Athletic Director will review submitted information. A student is not cleared for sports until the information has been reviewed and approved by the Athletic Director.