

## 2021-2022 Athletic Clearance

1. Get a Pre-Participation Exam and clearance from a medical doctor and have physical form signed (Forms available at <https://nhhs.nmusd.us/athletics> or in the Athletics Office)
  2. Go to [www.AthleticClearance.com](http://www.AthleticClearance.com)
  3. New Students/FR: Create an account; have medical insurance card with you  
(Return athletes: Log-in to existing account)
  4. Complete required information
  5. Upload your physical 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 and turn in at the Athletic Office
- \*\*The Confirmation/Consent form must be submitted to the Athletics Office in order to be cleared \*\***  
(Please email to JTNguyen@nmusd.us)

*\*If you cannot upload your physical and insurance card, you may turn it in with your signed Confirmation/Consent Page*

1. [www.AthleticClearance.com](http://www.AthleticClearance.com) Create Account (only one per family)
2. Get clearance from a Medical Doctor
3. Provide a copy of student athlete medical insurance card:

Examples:

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: \_\_\_\_\_ L: \_\_\_\_\_ Corrected: \_\_\_\_\_ Y: \_\_\_\_\_ N: \_\_\_\_\_ Pupils: \_\_\_\_\_ Equal: \_\_\_\_\_ Unequal: \_\_\_\_\_

EMERGENCY INFORMATION

Parent's Name: \_\_\_\_\_

Medical Information

Medical	Normal	Abnormal Findings
Heart		
• Murmur (systolic, diastolic, high, low, etc.)		
• Arrhythmia (bradycardia, tachycardia, etc.)		
• Chest pain (exercise, rest, etc.)		
• Fainting		
• Blood pressure		
• Headaches		
• Allergies		
• Medications		
• Family history (heart, etc.)		
• Other		
MUSCULOSKELETAL		
• Neck		
• Shoulder		
• Elbow		
• Wrist		
• Hand		
• Hip		
• Knee		
• Ankle		
• Foot		
• Other		

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 one sport

☐ For certain sports

Reason/Recommendation: \_\_\_\_\_

I have evaluated the above named student and completed the preparticipation physical examination. The physician does not present apparent contraindications to practice, travel, and part take in the sports as advised above. A signed Preparticipation Physical Examination form must be submitted to the school at the request of the physician. If conditions arise after the physician has been cleared for participation, the physician may rescind the clearance and the physician's responsibility is completely explained to the school and parent/guardian.

Name of Physician/Provider (Office stamp required): \_\_\_\_\_ (MD, DO, NP, or PA) Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician/Provider: \_\_\_\_\_

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 0018958979 07 97

Name: First M Last Gender

For information about your Health Plan benefits: 1-800-464-4000

After-hours nurse advice: 1-888-578-6225 kp.org

CalOPTIMA Direct

DOB: 05/21/1997 Effective Date: 11/01/2007

CIN #: 96472807E

Pharmacy Services #: (888)587-8088 RxBin: 610575

Vision Services #: (800)438-4560 RxPCN: CALOP113

4. HOW TO FIND the Confirmation Message:

Click on the word View

Print, sign and turn it at the Athletic Office

Clearances

Start Clearance Here!

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

**\*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 JTNguyen@nmusd.us)**
2. **Preparticipation Physical Evaluation Form signed by a physician (uploaded) \*Physicals are good for one year after your 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.**

*\*If you cannot upload your physical and insurance card, you may turn it in with your signed Confirmation/Consent Page to the Athletics Office\**

The screenshot shows the 'Confirmation Message' page on AthleticClearance.com. The page includes a header with navigation links: INJURIES, MY ACCOUNT, CONTACT US, SIGN OUT, and CLEARANCES. The main content area is titled 'Confirmation Message' and includes a 'Go Back' link. The message is addressed to a parent/guardian and states that the student has started the Athletic Clearance process to participate in Wrestling for Estancia. It explains that the final step requires parent and student signatures in agreement of the consent to participate. The message asks the parent to read, sign, and return the form to the Athletic Office, along with a completed physical form and medical insurance card copy if unable to upload. The parent's consent is indicated by a checked box. The student's consent is also indicated by a checked box. The form includes fields for Parent Signature, Student Signature, and Date, each with a red 'X' indicating a required field. A large red 'EXAMPLE' watermark is overlaid diagonally across the form. At the bottom, there is a section titled 'Would you like to apply this Clearance to additional sports/activities?' with a grid of checkboxes for various sports. The 'Submit' button is circled in red, and a 'Print' button is also visible.

**ATHLETICCLEARANCE.COM** INJURIES MY ACCOUNT CONTACT US SIGN OUT CLEARANCES

**Confirmation Message** Go Back

Dear [REDACTED]

This message is to let you know [REDACTED] has started the Athletic Clearance process to participate in Wrestling for Estancia.

The final step in this process requires parent and student signatures in agreement of the consent to participate. Please read, sign and return to the Athletic Office (along with your completed physical form and medical insurance card copy if you were unable to upload).

☒ I hereby give my consent for [REDACTED] hereafter named student, to compete in athletics. I authorize the student to go with and be supervised by a representative of the school on any trips. In case this student becomes ill or is injured, you are authorized to have the student treated and I authorized the medical agency to render treatment. I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or said hospital it is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the school representative to give specific consent to any such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. This authorization shall remain effective until the end of the school year unless sooner revoked in writing and delivered to the school.

Parent Signature ☒

Student Signature ☒

Date ☒

Thank You,  
Estancia  
Athletic Department

**EXAMPLE**

☒ **Would you like to apply this Clearance to additional sports/activities?**

<input checked="" type="checkbox"/> Baseball	<input type="checkbox"/> Basketball, Boys	<input type="checkbox"/> Basketball, Girls	<input type="checkbox"/> Cross Country, Boys
<input checked="" type="checkbox"/> Cross Country, Girls	<input type="checkbox"/> Football (11 man)	<input type="checkbox"/> Golf, Boys	<input type="checkbox"/> Golf, Girls
<input type="checkbox"/> Soccer, Boys	<input type="checkbox"/> Soccer, Girls	<input checked="" type="checkbox"/> Softball	<input type="checkbox"/> Swimming & Diving, Boys
<input type="checkbox"/> Swimming & Diving, Girls	<input type="checkbox"/> Tennis, Boys	<input type="checkbox"/> Tennis, Girls	<input type="checkbox"/> Track & Field, Boys
<input type="checkbox"/> Track & Field, Girls	<input type="checkbox"/> Traditional Competitive Cheer	<input type="checkbox"/> Volleyball, Boys	<input type="checkbox"/> Volleyball, Girls
		<input type="checkbox"/> Water Polo, Boys	<input type="checkbox"/> Water Polo, Girls

☒ I, the parent/guardian of the student, acknowledge that my electronic signatures will be applied to all additional clearances.



## 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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU:	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your heart ever race or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> A Heart Infection <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever ordered a test for your heart (for example, ECG/EKG, echocardiogram)?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you get lightheaded or feel more short of breath than expected during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had an unexplained seizure?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you get more tired or short of breath more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace, orthotics, or other assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you have a bone, muscle or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do any of your joints become painful, swollen, feel warm, or look red?	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you have any history of juvenile arthritis or connective tissue disease?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
27. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
28. Is there anyone in your family that has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you have groin pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
32. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you had a herpes or MRSA skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>
36. Do you have a history of seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
37. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
39. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
40. Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
41. Do you get frequent muscle cramps when exercising?	<input type="checkbox"/>	<input type="checkbox"/>
42. Do you or someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>
43. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
44. Have you had any eye injuries?	<input type="checkbox"/>	<input type="checkbox"/>
45. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
46. Do you wear protective eyewear, such as goggles, or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
47. Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>
48. Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
49. Are you on a special diet or do you avoid certain types of food?	<input type="checkbox"/>	<input type="checkbox"/>
50. Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
51. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES ONLY	Yes	No
52. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
53. How old were you when you had your first menstrual period?	<input type="text"/>	<input type="text"/>
54. How many periods have you had in the last 12 months?	<input type="text"/>	<input type="text"/>
<b>Explain "yes" answers here:</b>		

**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: \_\_\_\_\_



**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, myopia, MVP, aortic insufficiency)		
Eyes/ Ears/ Nose/ Throat ● Pupils equal ● Hearing		
Lymph Nodes		
Heart <sup>1</sup> ● Murmurs (auscultation standing, supine, +/- Valsalva) ● Location of point of maximal impulse (PMI)		
Pulses ● Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) <sup>2</sup>		
Skin ● HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic <sup>3</sup>		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/ Arm		
Elbow/ Forearm		
Wrist/ Hand/ Fingers		
Hip/ Thigh		
Knee		
Leg/ Ankle		
Foot/ Toes		
Functional ● Duck-walk, single leg hop		

<sup>1</sup> Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

<sup>2</sup> Consider GU exam if in private setting. Having third party present is recommended.

<sup>3</sup> 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, tryout, 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: (print/ type/ stamp) \_\_\_\_\_ (MD, DO, NP, or PA) Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician/ Provider: \_\_\_\_\_