



Tulare Western Sport Clearances

All **COMPLETED** packets are turned into the **NURSE** prior to participation for a clearance slip.

There are 4 items needed to be cleared to play sports:

- **Register** for FamilyID/ Arbiter Sports for the current school year
- **Drug consent form** signed by parents (these are good for the school year)
- **Up to date physical** (physicals are good for one year after date of completion)
- **Athletic Registration Form** (these are good for the school year)

FamilyID

Sign up for your secure FamilyID/ Arbiter Sports (<https://account.familyid.com/signup>) account by entering your family name, email address, and password. (**SAVE** your password.) You will receive an email with a link to activate your account. *FamilyID will need to be kept current each school year.*

- 1) Click on the link in your email activation, which will log you into FamilyID.
- 2) Click "find programs"
- 3) Type "Tulare Western" in the box that says type organization name, keyword to find program.
- 4) Click "find"
- 5) Click "(current school year) **Athlete** Registration"
- 6) Complete the registration form
- 7) Click "Submit" to finish registration.
- 8) Continue until the confirmation page appears.

Drug Consent Form

We will be doing random drug testing on campus. This form is good for the current school year. **IF** you're taking a prescription medication, please provide documentation from the doctor to the nurse.

Physical

Physicals need to be completed by a physician (not a chiropractor) and are good for one year after the date of completion. FamilyID will send out an email 30 days prior to expiration and it is your responsibility to keep it current.

Athletic Registration Form

Please make sure this is accurate and updated for the current school year.

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____
 Name _____ Date of birth _____
 Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
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 Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, lightheadedness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, aortic bicuspid aortic valve, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
JOINT AND BONE QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALE ONLY		
25. Do you have any history of juvenile arthritis or connective tissue diseases?			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 that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION			Male	Female			
Height	Weight		BP	Corrected			
		Pulse	Vision R 20'	L 20'			
			Y	N			
MEDICAL		NORMAL			ABNORMAL FINDINGS		
Appearance							
<ul style="list-style-type: none"> Melan stigmata (kyphosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 							
Eyes/ears/nose/throat							
<ul style="list-style-type: none"> Pupils equal Hearing 							
Lymph nodes							
Heart*							
<ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 							
Pulses							
<ul style="list-style-type: none"> Simultaneous femoral and radial pulses 							
Lungs							
Abdomen							
Genitourinary (males only) ^b							
Skin							
<ul style="list-style-type: none"> HSV lesions suggestive of MRSA, linea corporis 							
Neurologic ^c							
MISCELLANEOUS							
Neck							
Back							
Shoulder/arm							
Elbow/forearm							
Wrist/hand/fingers							
Hip/leg							
Knee							
Leg/ankle							
Foot/heel							
Functional							
<ul style="list-style-type: none"> Duck-walk, single leg hop 							

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
 *Consider full exam if in private setting. Having third party present is recommended.
 *Consider cognitive evaluation or baseline neuropsychologic testing if a history of significant concussion.

- 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 examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice 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 parents, 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 (print/type) _____ Date _____
 Address _____ Phone _____
 Signature of physician _____, MD or DO

TULARE WESTERN HIGH SCHOOL DISTRICT Athletic and Activity/Club Registration Form 2019/2020

My student wishes to participate in the following sports or activities

Cross Country Baseball Softball Badminton Flag Football Tackle Football Hockey Swimming
 Soccer Tennis Golf Water Polo Basketball Volleyball Cheerleading Drill Team
 Track & Field Wrestling Band/Orchestra Other()

All prospective participants must complete these materials, provide proof of medical insurance and have a parent/guardian signature authorizing their participation prior to participation in any activity or practice.

Student Name (Please Print)	School	Date of Birth	Grade
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Address - Street Apt. City Zip Home Phone

CALIFORNIA LAW The California Education Code (Sections 32221-32224 and 49470-49474) requires that each member of an athletic team shall have insurance coverage for medical and hospital expenses in an amount of at least \$1,500 while practicing for or participating in athletic activities under the jurisdiction of a public school district. "Member of an athletic team" means member of any extramural athletic team engaged in athletic events on or outside the school grounds, maintained or sponsored by the educational institution or a student body organization thereof. "Member of an athletic team" also includes members of school bands or orchestras, cheerleaders and their assistants, pompon girls, team managers and their assistants, and any student or pupil selected by the school or student body organization to directly assist in the conduct of the athletic event, including activities incidental thereto, but only while such members are being transported by or under the sponsorship or arrangements of the educational institution or a student body organization thereof to or from a school or other place of instruction and the place at which the athletic event is being conducted.

Under state law, school districts are required to ensure that all members of school athletic teams have accidental injury insurance that covers medical and hospital expenses. This insurance requirement can be met by the school district offering insurance or other health benefits that cover medical and hospital expenses. Some pupils may qualify to enroll in no-cost or low-cost local, state or federally insured program. Information about these programs which include other comparable no-cost or low-cost local, state or federally sponsored health insurance programs, may be obtained by calling 1-800-722-3365 or the Healthy Families and Medical Programs Information Line at 1-800-880-5305.

INSURANCE PROTECTION Parents/Guardians must provide proof of insurance and complete and sign the following athletic waiver of insurance as evidence of other insurance coverage, or purchase Student Accident Insurance made available by the Tulare Union High School District before the student is eligible to participate in athletic events.

Option A Personal Insurance - I hereby declare that my student,

_____ has medical insurance in the amount of at least \$1,500 administered by _____ Insurance Co., Policy # _____, which will provide coverage for medical and hospital expenses resulting from accidental bodily injury while practicing for or participating in athletic events. Therefore, I do not want my student to subscribe to membership in the insurance program made available through the school district for accidental bodily injury and hereby release the Governing Board and school officials of the Tulare Western High School District from any and all responsibility to provide the insurance required under California Education Code Section 32220-32224. I WILL NOTIFY THE SCHOOL OF ANY CHANGE OR LAPSE IN THE ABOVE COVERAGE.

A copy of student's proof of medical insurance is attached.

Option B I wish to participate in the Student Accident Plan made available by Tulare Western High School District. An insurance enrollment form should accompany this form, or you can obtain one online at the Student Insurance provider website.

1. Log on to www.peinsurance.com. Under "Products", click on "Students", then click the appropriate link for a Brochure in English or Spanish. You may also sign-up online and print proof of your coverage (attach to this document) OR 2.

Print Brochure, complete and bring to your coach or teacher to forward to the insurance company with your payment.

A copy of student's proof of insurance is attached.

_____ Date

Signature of Parent/Guardian

-OVER-

SPORTS WARNING STATEMENT

Participating in competitive athletics may result in severe injury, including paralysis or death. Players can reduce the risk by reporting all physical problems to their coaches, following coaches' instructions regarding playing techniques, training and other team rules, etc., and agreeing to obey such instructions. Even if all these requirements are met, a serious accident may still occur.

PARENT PERMISSION

In consideration of the permission granted, we, the undersigned, hereby **RELEASE, DISCHARGE** and **HOLD HARMLESS** the Tulare Western High School District from all liability arising out of or in connection with the identified athletic sport/activity. The release and discharge of the Tulare Western High School District from all liability includes any defect or alleged negligence attributed to the Tulare Western High School District or any of its coaches, agents, instructors, teachers or any assistants supervising, directing or instructing in the athletic sport/activity. (_____)(to be initialed by the student and/or parent or guardian)

I, _____, being the parent/legal guardian of _____ (student), have read the above release. I understand and agree to its terms. I understand that all sports can involve **MANY RISKS OF INJURY** including, but not limited to, those risks outlined above.

In the event of an accident, or sudden illness, the school district has my permission to render whatever emergency medical treatment may be deemed necessary for the above named student.

I am signing this document on my own behalf, as well as on behalf of my student athlete.

_____ Date _____

Signature of Parent/Guardian

**TULARE JOINT UNION HIGH SCHOOL DISTRICT
STUDENT ATHLETE DRUG TESTING CONSENT FORM**

I understand after having read the Drug Testing Policy for the Tulare Joint Union High School District, set forth in Board Policy and Administrative Regulation 5131.61, that out of concern for my safety and health, the Governing Board and the District have established and enforce rules and consequences regarding the use of illegal drugs and controlled substances. I realize that the personal decisions that I make daily in regard to the use of illegal drugs or controlled substances may affect my health and well-being, pose a danger to those around me, and reflect negatively upon the District athletic program with which I am associated. If I choose to violate school policy regarding the use of illegal drugs or controlled substances, I understand that I will be subject to the restrictions of my participation as outlined in the policy.

I authorize Tulare Joint Union High School District to conduct a test on a urine specimen which I provide to test for illegal drugs and controlled substances, including but not limited to those drugs and controlled substances identified in District policy and regulation and/or set forth below. I also authorize the exchange of information concerning the results of such a test between the Tulare Joint Union High School District, my parent(s) and/or guardian(s), and the contracted drug testing agency, Recovery Resources.

This shall be deemed a consent pursuant to the Family Education Right of Privacy Act (20 U.S.C. § 1232g; 34 C.F.R. Part 99) and the Education Code (sections 49076 et seq.) for the release of the above information to the parties named above.

Dated: _____

Print Student's Name

Student Signature

PLEASE INDICATE ANY PRESCRIPTION DRUGS YOUR CHILD IS CURRENTLY TAKING AND PROVIDE DOCUMENTATION TO VERIFY SAME WITH THIS FORM:

I have read and agreed to the above terms of participation of my son/daughter.

Dated: _____

Print Parent/Guardian Name

Parent/Guardian Signature

The testing service will include tests for, but not be limited to, one or more of the following illegal drugs and/or controlled substances: marijuana metabolite, cocaine metabolite, opiates, phencyclidine (PCP), amphetamines, alcohol, benzodiazepines, barbiturates, propoxyhene (Darvocet), methadone, oxycotin, designer drugs and steroids.

Parents may withdraw authorization to test students, with written notification to Associate Superintendent at the District Office: 426 N. Blackstone St., Tulare, California 93274. The only consequence for such withdrawal is that the student will no longer be able to participate in District athletics.