OXNARD UNION HIGH SCHOOL DISTRICT
Students First: every day, every school, every classroom

ATHLETIC CLEARANCE PACKET

1. All prospective Athletes are required to register on-line at AthleticClearance.com before attending any try-out and/or practice.

2. After registering online, use the Dr./Parent Consent form on the reverse side:

   a. Have your Doctor sign and date the form.
   b. Parents and Students need to sign the form.
   c. Then turn it into Mrs. Amerio or Mrs. Perez in the office.

ID # Grade

First Name

Last Name Sport(s)

Annual Physical Examination

ATHLETE NAME: _____ **Date of Birth:** _____

Ht: _____Wt: _____ 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: _____ * Signature: **X**_____Date:_____

Address:_____State License #:_____

* The above-signed physician is NOT responsible for any ensuing medical problems or litigation.

Parent/Student Consent

I hereby give my consent for _____, 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 and all 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 _____ Phone _____

Student Signature _____

Date _____

Thank You,
Camarillo High School
Athletic Department