# Vista High School

## Athletic Clearance Packet

1) Physical Examination
2) Medical Information Release Form
3) Concussion Baseline Checklist

Please turn in forms to Athletic Trainer or respected coach:

Ms. Melissa Hutzell, ATC
Vista High School
1 Panther Way
Vista, CA 92084
760-726-5611 x71625
melissahutzell@vistausd.org

***Please be sure you read and fill out forms to their entirety. Lack thereof will delay participation of your student-athlete.***

# VISTA UNIFIED SCHOOL DISTRICT

Athletic Screening History & Physical Exam

**Please indicate**:

[ ] Mission Vista HS [ ] Rancho Buena Vista HS [ ] Vista HS

| | |
|---|---|
| Student Name: | Student ID #: |
| Address: | Date of Birth: |
| City/Zip: | Graduating Year: |
| Home Phone: | Parent Name / Cell # : |
| Emergency Contact / Phone: | Parent Name / Cell # : |
| Sport: | |

## EXPLANATION OF SCREENING PHYSICAL

I realize that the medial evaluations performed are only screens in order to evaluate general health, to disclose existing problems, and to determine my son/daughter's dynamic ability to participate in a given sport so that obvious conditions which might be damaged or aggravated by competitive sports can be found, evaluated and treated so as to prevent further injury. This examination does not guarantee against injury. Physicals must be renewed no later than ONE calendar year from physical examination date.

Parents Initials _____

## AWARENESS OF RISK

STUDENT AND PARENT - I am aware that playing/practicing sports can be a dangerous activity involving many risks of injury. I understand that the risks of participation include, but are not limited to, death, serious neck and spinal cord injuries that may result in complete or partial paralysis, brain damage, serious internal injury to virtually any internal organs, bones, joints, muscles, tendons, or any other aspect of the skeletal system, and serious injury or impairment to other aspects of my body, general health and wellbeing. I understand that the risks of participant may result not only in serious injury, but in impairment of my future ability to earn a living, to engage in other business, social and recreational activities, and generally to enjoy a good life. Because of the dangers of participant in sports, I recognize the importance of following coaches' instructions regarding playing techniques, training, equipment and other team rules, etc. both in competition and practice and agree to obey such instructions.

Parents Initials _____

## PERMISSION FOR TREATMENT

I hereby grant permission to the Athletic Trainer, Team Physicians and those professional personnel designated by Vista Unified School District to treat my son/daughter in the event of an injury. In the event of a serious injury, if I am unable to give my consent at that time, this consent is to include any and all emergency procedures deemed necessary by the attending emergency personnel. I also understand that in the event of injury, every reasonable attempt will be made to contact me prior to securing medical treatment beyond basic first-aid.

Parents Initials _____

## CIF CONCUSSION INFORMATION

http://vhs.vistausd.org/wp-content/uploads/2017/07/CIF-Concussion-Information.pdf

I agree that the safety of the athletes always comes first. I have read the CIF Concussion information sheet and am familiar with the signs and symptoms of a concussion. I understand and support the decision that any athlete suspected of a serious head injury may be removed from a game or practice immediately and will not be allowed to return to activity until medically cleared by a physician. I understand that CA STATE LAW 2127 states that return to competition CANNOT be sooner than 7 days after evaluation by a physician (MD/DO) who has made the diagnosis of concussion, and ONLY after completing a gradual return to play protocol.

Parents Initials _____

## CIF SUDDEN CARDIAC ARREST INFORMATION

http://vhs.vistausd.org/wp-content/uploads/2017/07/Sudden-Cardiac-Arrest-Information.pdf

I have read the CIF Sudden Cardiac Arrest information sheet and am familiar with the signs and symptoms of sudden cardiac arrest. I understand that any athlete who faints will be removed from athletic activity and may not return to sport until he/she is evaluated and cleared by a licensed health care provider (MD/DO).

Parents Initials _____

**PROOF OF INSURANCE**

In compliance with California Education Code 32221, I certify that there is in effect at this time insurance coverage for medical expenses resulting from bodily injury of at least $5,000 for my son/daughter, and that this coverage will remain in effect throughout the time that he/she participates in sports. I also give my permission for the above named student to participate in sports, including regularly scheduled trips by supervision school transportation.

Parents Initials _____ Insurance Carrier _____ Policy # _____

**I have read the above statement, EXPLANATION OF SCREENING PHYSICAL, AWARNESS OF RISKS, PERMISSION FOR TREATMENT, CIF CONCUSSION INFORMATION, CIF SUDDEN CARDIAC ARREST INFORMATION, & PROOF OF INSURANCE and understand them fully and agree/consent to their contents.**

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

## Health History - Please answer the following in the check box provided. Explain "yes" answers in the box below.

1. Have you ever been hospitalized (overnight)? [ ] Yes [ ] No
2. Have you ever had surgery? [ ] Yes [ ] No
3. Are you currently taking medication? [ ] Yes [ ] No
4. Do you have any allergies (medicines, pollen, bees)? [ ] Yes [ ] No
5. Have you ever passed out during exercise? (not from heat) [ ] Yes [ ] No
6. Have you ever been dizzy during exercise? (not from heat) [ ] Yes [ ] No
7. Have you ever had chest pain? [ ] Yes [ ] No
8. Do you tire more quickly than your friends during exercise? [ ] Yes [ ] No
9. Have you ever had high blood pressure? [ ] Yes [ ] No
10. Have you ever been told you had a heart murmur? [ ] Yes [ ] No
11. Have you ever had racing of your heart or skipped beats? [ ] Yes [ ] No
12. Has anyone in your family died of heart problems or a sudden death before age 40? [ ] Yes [ ] No
13. Does anyone in your family have Marfan's Syndrome? [ ] Yes [ ] No
14. Do you have any skin problems (itching, rashes, breaking out)? [ ] Yes [ ] No
15. Have you ever had a head injury? [ ] Yes [ ] No
    Have you ever been knocked out? [ ] Yes [ No
    Have you ever had a seizure? [ ] Yes [ ] No
    Have you ever had a burner/stinger? (pain from neck to arm) [ ] Yes [ ] No
16. Have you ever had heat cramps? [ ] Yes [ ] No
    Have you ever been dizzy or passed out in the heat? [ ] Yes [ ] No
17. Do you use special pads or orthotic braces? [ ] Yes [ ] No
18. Have you ever injured (broken/fractured, sprained, dislocated)?
    [ ] Hand / fingers [ ] Shoulder [ ] Hip [ ] Shin / calf [ ] Wrist / forearm [ ] Neck [ ] Thigh
    [ ] Ankle [ ] Elbow [ ] Chest/ribs [ ] Knee [ ] Foot / toes [ ] Upper arm [ ] Back
    [ ] Stress fractures?
19. Have you ever had?

[ ] Mononucleosis [ ] Diabetes [ ] Hepatitis [ ] Headaches (frequent) [ ] Eye/ear injuries
[ ] Tuberculosis [ ] Measles [ ] Hernia(s) [ ] Asthma [ ] Ulcers
[ ] Sickle cell trait/disease

20. When was your last tetanus shot? _____

21. About your weight: Do you think you are . . . [ ] just Right? [ ] too Heavy? [ ] too Thin / Light?

22. For females: Are your periods [ ] Regular/monthly? [ ] Irregular / skip months?

When was your first period and how old were you? _____ When was your last period? _____

**Please ask the doctor to address any questions that you may have. [All discussions are kept confidential.]**

**Please Explain and "YES" answers here:**

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# Physical Examination

(To be completed by Medical Personnel)

Height _____ Blood Pressure _____ (sitting, left arm)

Weight _____ Pulse _____

Vision (optional)
Left eye 20 / _____
Right eye 20 / _____
Both eyes 20 / _____

with / without glasses

| | |
|---|---|
| 1. Skin | |
| 2. Head | |
| 3. Eyes (PERLA, EOMI, Fundi) | |
| 4. Ears nose, throat | |
| 5. Neck | |
| 6. Lymphatic | |
| 7. Respiratory | |
| 8. Cardiovascular<br>Heart (murmurs)? | |
| 9. Abdomen | |
| 10. Extremities | |
| 11. Neurological<br>Reflexes | |
| 12. Orthopedic | |
| Cervical spine/back | |
| Arms/elbows/wrist/hands | |
| Hips | |
| Knees | |
| Ankles/feet | |

**√ = within normal limits** **+ = see comments** **X= omitted**

## MEDICAL CLEARANCE

(As appropriate for age and development)

[ ] Full contact/collision level (full, unrestricted participation)

[ ] Limited contact / impact

[ ] Non contact: strenuous

[ ] Non contact: non-strenuous

[ ] Clearance deferred or no participation at this time because:

[ ] Needs clearance by specialist

[ ] Orthopedist [ ] Cardiologist

Other : _____

[ ] Needs to complete rehabilitation for current condition(s) prior to participation

**Comments / Recommendations:**

***Physician's Statement:***

(Student's name) _____ was examined by me on _____(date) and found physically fit to engage in high school athletics. Results are to encourage, but in no way guarantee the fitness and safety of this athlete.

Practitioner signature: _____ Date: _____

M.D. / D.O. / N.P. / P.A. / D.C.

**Do not sign without student's name filled in**

**Physician's Office Stamp HERE (REQUIRED)**

*CONFIDENTIAL*

# VISTA UNIFIED SCHOOL DISTRICT

## MEDICAL INFORMATION RELEASE FORM FOR CO-CURRICULAR ACTIVITY

This form is provided to the coach and will be taken with the team wherever they travel. Please fill out completely and be specific. The form gives parental consent for any staff/chaperone approved by the school principal to secure emergency services (medical, dental, paramedic, ambulance) for the student at the parent/guardian expense. Efforts will be made to contact the parent/guardian prior to treatment or hospitalization. An authorization with a physician's signature must be attached if the athlete takes any prescription medication.

| | |
|---|---|
| Student Name: | Sport(s): |
| Parent/Guardian Name: | Graduating Year: |
| Address: | City/ZIP: |
| Home Phone: | Mother Cell: Mother Work: |
| | Father Cell: Father Work: |

IN CASE OF EMERGENCY, A REPRESENATIVE OF THE VUSD ATHLETIC DEPARTMENT HAS THE AUTHORITY TO SECURE MEDICAL OR SURGICAL TREATMENT AND TRANSPORT AS NECESSARY. EVERY ATTEMPT WILL BE MADE TO CONTACT THE EMERGENCY PERSONS LISTED BELOW.

| | |
|---|---|
| Family Doctor: | Dr. Phone #: |
| Emergency Person to Contact: | Phone #: |
| Relationship to Student: | |
| Emergency Person to Contact: | Phone #: |
| Relationship to Student: | |

List all information helpful to a physician in case of emergency including information which school staff and chaperones need to be aware of regarding the student's safety. Updated information shall be provided by the parent/guardian.

| | |
|---|---|
| MEDICAL PROBLEMS:<br>(diabetes, asthma, seizures, sickle-cell trait, etc.) | TREATMENT: |
| ALLERGIES:<br>(food, bee stings, medication, etc.) | TREATMENT: |

SCHOOL RULES ARE IN EFFECT FOR ALL SCHOOL SPONSORED ACTIVITIES

MEDICATION: Prescription and non-prescription medications are permitted only with a written statement from the physician and parent/guardian indicating desire that the District assist the student as set forth by the physician. If prescription or non-prescription medication is necessary, an AUTHORIZATION FOR MEDICATION ADMINISTRATION must be attached. I understand that staff/chaperones may assist my student in taking the medicine(s) as directed by my physician. I will provide the medicine(s) in the prescription container(s) labeled with the name of my student, the prescribing physician's name, and the time and dosage of medication prescribed. I agree to hold harmless and indemnify the Vista Unified School District, its officers, employees, agents or chaperones from and against any and all liability, loss, expense or claims for illness, injury or damage any student may incur from medication assistance.

I UNDERSTAND THAT BY SIGNING THIS FORM:

1. I give permission for my son or daughter to participate in Vista Unified School District athletics.
2. I give permission for staff/chaperones to provide first aid care and secure emergency care at my expense if needed.
3. I release Vista Unified School District, its officers, employees, agents and its chaperones from any and all liability, loss, expense or claim for illness, injury or damages that may arise from participation in the athletics program or any associated activity. Further, I understand that the District does not provide accident/medical insurance for students and that I am expected to provide such insurance coverage.
4. I am aware that injuries may occur to the athlete while participating in interscholastic athletics. I have been advised of this danger.

_____ _____

Name of insurance company Insurance Policy/Group Number

**X**_____ _____ **X**_____ _____

**Parent/Guardian Signature** **Date** **Parent/Guardian Signature** **Date**

***BOTH PARENTS/GUARDIANS MUST SIGN ABOVE***

# CIF GRADED CONCUSSION SYMPTOM CHECKLIST
# BASELINE

## Purpose:

*This checklist will provide us with a sense of how you feel on a normal daily basis. The majority of students should experience "zeros"; however, a small population of students may experience some of these symptoms on a daily basis (regular headaches, migraines, visual deficits, etc.). Should you sustain a concussion, we will utilize your "baseline" as means of showing us what exactly "normal is for you." You will be asked to complete this same checklist after concussion diagnosis until you are back to normal values. Once this is achieved, you may proceed to your gradual return to play protocol with your certified athletic trainer. Absolutely, no activity will be permitted until you are back to your normal baseline scores.

## Instructions:

1. Grade the 22 symptoms with a score of 0 to 6.
   0=no symptom reported
   6= "worst pain in your entire life"

2. Please answer as accurate as possible.

3. How many concussions have you had? _____

| | None | Mild | Moderate | | Severe | | |
|---|---|---|---|---|---|---|---|
| Headache | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| "Pressure in Head" | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Neck Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Nausea or Vomiting | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Dizziness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Blurred Vision | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Balance Problems | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sensitivity to Light | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sensitivity to Noise | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Feeling Slowed Down | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Feeling like "in a fog" | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| "Don't Feel Right" | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Difficulty Concentrating | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Difficulty Remembering | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Fatigue or Low Energy | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Confusion | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Drowsiness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Trouble Falling Asleep | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| More Emotional Than Usual | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Irritability | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sadness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Nervous or Anxious | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| TOTAL | 0 | | | | | | |
| TOTAL SYMPTOM SCORE (Sum of all column totals) | | | | | | | |