CORONA-NORCO UNIFIED SCHOOL DISTRICT

AUTHORIZATION FOR EMERGENCY MEDICAL CARE (WAIVER)

For Office Use Only

Student #:____________ ***Use ballpoint pen. Press hard so last copy is clear. Please Print Clearly***

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for student-athletes who become ill or injured while under school authority, when parents or guardians cannot be easily reached.

1. STUDENT NAME: (last)__________ (first)__________ (m.i.)____ GRADE:____
   ADDRESS:__________ SEX:____ AGE:____ DATE OF BIRTH:________
   CITY:__________ ZIP:________ PHONE:________
2. FATHER'S NAME:__________ PHONE:________ CELL:________
   EMPLOYER:__________ PHONE:________
3. MOTHER'S NAME:__________ PHONE:________ CELL:________
   EMPLOYER:__________ PHONE:________
4. Name of person, other than parent or guardian, who is authorized to approve emergency medical treatment:
   __________ PHONE:________
5. FAMILY DOCTOR:__________ PHONE:________
   HEALTH INSURANCE CO.:__________ **POLICY I.D.#:**________

In the event reasonable attempts to contact me/us at the above locations, or other person(s) named in item 4 above fail, full authorization is given for (1) the administration of any treatment deemed to be necessary by a medical practitioner; and (2) the transfer of son/daughter or ward to any medical practitioner; and (3) the transfer of son/daughter or ward to any licensed hospital or emergency clinic reasonably accessible. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required and given to provide Authority and Power on the part of school authorities and aforesaid agent(s) to give reasonable care. Facts are given below concerning the student's medical history which a medical practitioner should know.

Allergies: __________ Allergies to specific medication(s): __________

Any previous significant medical problems: __________

Sickle Cell Trait/Disease: ☐Yes ☐No **Asthma:** ☐Yes ☐No

ATHLETIC TRANSPORTATION PERMIT

Dear Parent/Guardian:

Your consent is required to permit your child to be transported for athletic activities. No student will be permitted to participate in athletic activities off campus without a signed permission slip.

______**I DO** permit my child to be transported by the Corona-Norco Unified School District or District approved charter bus service.

I hereby grant permission for the District to allow emergency medical treatment if required and accept liability for such treatment.

<u>As stated in California Education Code Section 35330</u>, I understand that I hold the Corona-Norco Unified School District its officers, agents and employees harmless from any and all liability and claims, which may arise out of or in connection with

________________ __________
Parent/Guardian Signature **Date**

Athletic Office Use Only

CNUSD Athletic Clearance Date:________ **Season:** Fall Winter Spring **Level:** V JV F **Sport:**________

Physical Exam ________ **Personal Insurance**________ **Myers Stevens:** All Both Football

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

W.H. 593-12
Rev. 10/16

Name ______________________ Date of Birth ______________

PHYSICIAN REMINDERS

1. 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 or use a helmet?
2. Consider reviewing questions on cardiovascular symptoms.

EXAMINATION		
Height	Weight	☐ Male ☐ Female
BP / (/) Pulse	Vision R 20/	L 20/ Corrected ☐ Y ☐ N

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[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echo-cardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Condider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric 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 examinined 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

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