

MEDICAL CLEARANCE

PHYSICIAN'S STATEMENT

I hereby certify that the _____ was examined by me on _____, 20 ____
and was found physically fit to engage in the following sports:

SPORT(S) Circle all that apply: No Restrictions Cross Country Football Golf Tennis Volleyball Water Polo
Basketball
Soccer Wrestling Softball Swimming Track & Field Volleyball Pep/Cheer Baseball

NOTE: This form is only valid for the period of July 1, 2009 to June 30, 2010.

Special medical problems: _____

Physician's stamp must be placed here

(Signature of Physician)

INSURANCE INFORMATION AND CERTIFICATION

California Law requires: (1) That every member of an athletic team must have accidental bodily injury insurance providing at least \$1500 of scheduled medical and hospital benefits. (2) And, at least \$1500 accidental death benefits. A voluntary plan covering the required medical and death benefits is available for purchase at the school.

By signing this form below, I hereby certify that we carry insurance protection that fulfills state requirements and do not wish to purchase additional protection.

Our insurance is carried with: _____ Policy #: _____

Name of primary policy holder: _____

We have enrolled in the voluntary school plan: yes _____ no _____

SIGNATURES

By signing below I certify that all the information on this form is accurate and complete and I consent to have the above named student participate in athletics.

Parent/Guardian Signature: _____

Date: _____