

ATHLETIC INSURANCE CERTIFICATE

(Pupil's Last Name) (First Name) (Initial) (School) (Grade)

**THIS FORM MUST BE ON FILE WITH THE SCHOOL OF ATTENDANCE FOR VERIFICATION OF ELIGIBILITY
PRIOR TO PARTICIPATION IN ANY ATHLETIC EVENT**

NOTE: The California Education Code requires that every student have \$1,500 accidental medical insurance in order to participate in Athletics (Education Code 32220-24)

SECTION I: (If you have your own insurance coverage, please complete this section.)

My medical coverage insurance policy is for at least \$1,500 and is issued by:

(Name of Insurance Company)

(Policy Number)

I further assure that the insurance policy or policies I hereby verify will remain current and in force during the time the above named student performs any function within the scope of Education Code Sections 32220-24 and 35330-31 during the current school year.

As I do not have medical insurance coverage as defined in Education Code Sections 32220-24 and 35330-31, I have purchased accident insurance per the attached application.

Student's Name _____

I have checked for accident insurance as indicated below in order to meet the requirements of the California law (check the appropriate response(s)).

- Tackle Football Insurance (Covers tackle football only).
- School Time Insurance (Covers sports other than football).
- Full Time Insurance (Covers sports other than football).

(Name of Insurance Company)

(Policy Number)

SECTION II:

INDEMNIFICATION

I agree to indemnify and hold the Santa Ana Unified School District harmless against responsibility for insurance coverage required under the aforementioned Education Code Sections. By signing this statement, I agree to accept responsibility for all medical costs incurred by the above named pupil while participating in the school athletic program.

**YOUR ATTENTION IS DIRECTED TO THE FACT THAT MANY INSURANCE POLICIES EXCLUDE TACKLE FOOTBALL.
PLEASE CHECK YOUR POLICY CAREFULLY OR CONSULT YOUR INSURANCE CARRIER.**

SECTION III:

MEDICAL AUTHORIZATION

TO WHOM IT MAY CONCERN:

I the undersigned being the parent or legal guardian of _____, do hereby grant to any hospital, emergency center, doctor, nurse, and/or paramedic, authorization to grant treatment to my child, when accompanied by or escorted to the treating facility by a teacher, coach, teacher's aide, principal, or any member of the Santa Ana Board of Education. Further, should the attending physician determine after examination that life-saving surgery or other life-saving procedures may be necessary, permission is hereby extended to the above parties to grant same.

Additionally, I agree to hold harmless such personnel and the Santa Ana Board of Education by my action of granting said permission.

SECTION IV:

COMPETITIVE ATHLETIC PARTICIPATION WARNING

Participation in competitive athletics may result in severe injury, including paralysis, or death. Changes in rules, improved conditioning programs, better medical coverage, and improvements in equipment have reduced these risks BUT IT IS IMPOSSIBLE TO TOTALLY ELIMINATE SUCH OCCURRENCES FROM ATHLETICS.

Players can reduce the chance injury by obeying all safety rules in their sport, reporting all physical problems to their coaches, following a proper conditioning program and inspecting their own equipment daily. **DAMAGED EQUIPMENT MUST BE REPLACED IMMEDIATELY.**

EVEN IF ALL THESE REQUIREMENTS ARE MET, AND EVEN IF THE ATHLETE IS USING EXCELLENT PROTECTIVE EQUIPMENT, A SERIOUS ACCIDENT MAY STILL OCCUR. AS A CONDITION OF PARTICIPATION IN ATHLETICS BY _____

(Name of Athlete)

WE ACKNOWLEDGE THAT WE HAVE READ AND UNDERSTAND THIS WARNING STATEMENT.

(Signature of Student/Athlete)

(Signature of Father/Guardian)

(Signature of Mother/Guardian)

I declare under penalty of perjury that the above is true and correct.

(Date)

(Signature of Parent or Guardian)

(Printed Name)

(Address)

(Telephone)

Please complete form in duplicate (no carbon required) and return ALL copies to school.

For further information, please contact your school Athletic Director:

SANTA ANA HIGH — Boys: 567-4980; Girls: 567-4989

VALLEY HIGH — Boys: 241-6422; Girls: 241-6468

SADDLEBACK HIGH — Boys and Girls: 513-2900

CENTURY HIGH — Boys and Girls: 568-7057

SANTA ANA UNIFIED SCHOOL DISTRICT
SPORTS PHYSICAL SCREENING EVALUATION INFO

STUDENT ID# _____

DATE _____

ACTIVITY _____

NAME _____ SCHOOL _____ GRADE _____ M F

ADDRESS _____ CITY, ZIP _____ BIRTHDATE _____

HOME PHONE _____ EMERGENCY PHONE _____

1. I hereby give my consent for the above named student (son, daughter, ward) to compete in sports and to go with a representative of the school on any trips. We understand that while the risk of serious injury is low, a serious injury or death can occur as a result of athletic participation.

Signature of parent or guardian _____ Date _____

2. I hereby give my permission for a screening evaluation.

Signature of parent or guardian _____ Date _____

HEALTH HISTORY: To be completed by parents **before** doctor screening.

	YES	NO		YES	NO
Head injury/concussion	_____	_____	Bone/joint disorders	_____	_____
Eye/ear problems	_____	_____	(broken bones, dislocations,		
(disease/surgery)	_____	_____	trick joints, arthritis)		
Dizzy spells, fainting or convulsions	_____	_____	Heart trouble, rheumatic fever	_____	_____
Tuberculosis, asthma, bronchitis	_____	_____	Anemia, leukemia, bleeding		
Diabetes, hepatitis, jaundice	_____	_____	disorders	_____	_____
Kidney/bladder problems	_____	_____	Ulcers, stomach trouble	_____	_____
Allergies	_____	_____	Hernia	_____	_____
Taking medication regularly	_____	_____			

IF ANSWERED "YES" GIVE DETAILS: _____

FITNESS ASSESSMENT:	WEAKNESS/SATISFACTORY		WEAKNESS/SATISFACTORY
Lower body flexibility	_____	Upper body flexibility	_____
Adductor/abductor flex.	_____	Ballistic speed	_____
Upper body strength	_____	Lower body strength	_____
Cardio vascular assessment	_____		

Past athletic injury (last 12 months) treated by trainer: _____

Athletic Trainer's Signature _____ Date _____

SCREENING EVALUATION: To be completed by physician.

BP _____	HR _____	HT. _____	WT. _____
EYE CHART:	R _____	L _____	GLASSES/CONTACTS _____
HEENT	_____	HEART	_____
BRACES/TEETH	_____	LUNGS	_____
BACK	_____	ABDOMEN	_____
EXTREMITIES	_____	HERNIA	_____

SCREENING EVALUATION COMPLETE _____ FULL PARTICIPATION _____ MD CONSULTATION & CLEARANCE _____

MD RECOMMENDATIONS OR RESTRICTIONS _____

MD SIGNATURE _____ DATE _____