## **Santa Ana Unified School District**

## ATHLETICS MEDICAL SCREENING FORM

Last Name:		First: _	First: DOB: Gender (circle one) Male / Female				
Student ID # Grade:		·	Sport(s):				
Н	EALTH HISTOR	Y: TO BE COMPLETED	BY STUDENT-ATH	LETE AND PARENT PRI	OR TO MEDICAL SCREENING EVALU	JATION.	
Head injury of	oncussion loss of	memory, unconsciousne	acc narcictant has	ndaches	☐ Yes	□ No	
		nes, dislocations, swelli	☐ Yes	□ No			
	mia, bleeding disc		☐ Yes	□ No			
Kidney/bladde			☐ Yes	□ No			
Eye problems			☐ Yes	□ No			
Ulcers, stomac			☐ Yes	□ No			
		gh blood pressure, rheu	☐ Yes	□ No			
Ulcers, stomac	culosis, bronchitis	<u> </u>	☐ Yes ☐ Yes	□ No □ No			
	s, medicines, inse	ects etc.)	☐ Yes	□ No			
	spells, fainting o		☐ Yes	□ No			
Diabetes, hepa			☐ Yes	□ No			
Hernia			☐ Yes	□ No			
		es, please list medication	☐ Yes	□ No			
	es please comple provide details:		☐ Yes	□ No			
MEDICAL SCREENING EVALUATION: MUST BE COMPLETED BY YOUR PHYSICIAN AND DATED AFTER MAY 1ST OF THE CURRENT SCHOOL YEAR.   CLEARED FOR FULL PARTICIPATION  NOT CLEARED FOR PARTICIPATION:							
- CLEARED F	OR FULL PARTIC	IPATION		T CLEARANCE/FOLLOV			
MD RECOMMENDATIONS OR RESTRICTIONS:							
BP	HR	нт	WT	EYE CHART: R L	GLASSES/CONTACTS	BRACES/TEETH	
HEENT	HEART	LUNGS	ABDOMEN	HERNIA	BACK	EXTREMITIES	
MD PHONE NUMBER			MD PRINT NAME		MD STAMP		
DATE			MD SIGNATURE				
		DADENT C	ONSENT ACKNO	OWLEDGEMENT, AND	SIGNATURE		
					, SIGNAL ONL		
CONSENT: By	signing below, I	hereby give my permiss	sion for a screenin	g evaluation.			
authorize the is injured, you x-ray examin be rendered Practice Act of physician or care being reany and all s	e student to go u are authorize lation, anesthet under, the gene on the medical said hospital it equired, but is g uch diagnosis, t dvisable. This a	with and be supervised to have the studentic, medical, or surgiceral or special supervistaff of any accredite is understood that the provide authors and the streatment or hospital	ed by a represent treated and I cal diagnosis or ision of any phyed hospital, when authorization ority and power I care which the	ntative of the school authorized the medic treatment and hospit sician and surgeon lither such diagnosis conthe part of the scaforementioned phy	after named student, to compet on any trips. In case this stude cal agency to render treatment. cal care which is deemed advisa- censed under the provisions of or treatment is rendered at the of any specific diagnosis, treatre chool representative to give spe- sician in the exercise of his/her thool year unless sooner revoke	ent becomes ill or I consent to any able by, and is to the Medical office of said ment or hospital ecific consent to best judgment	
Parent Signature	<u>!</u>			Date			

## **Santa Ana Unified School District**

## **Post COVID-19 Athletic Clearance**

The California Interscholastic Federation (CIF) strongly recommends that student-athletes who test positive for COVID-19, not return to sports activities until cleared. This form is to be completed by a licensed healthcare provider (M.D., D.O., P.A., Nurse Practitioner). For further clarification please visit:

https://www.cifstate.org/covid-19/Resources/CIF\_Eval\_for\_CV-19\_RTP.pdf

Name of Student-Athlete:	DOB:
Participating Sport(s):	
COVID Case:	
☐ Asymptomatic (no symptoms) or mild sympt	coms (fever, myalgia, chills, and lethargy < 4 days)
☐ Moderate symptoms (fever, myalgia, chills o	r lethargy lasting >=4 days or hospitalized but not in ICU)
☐ Severe symptoms (hospitalized in ICU and/o	r MIS-C)
Some students, particularly those with moderate	to severe illness, may require a graduated return-to-play
(RTP) protocol once the student has been cleared	by a LHCP (cardiologist for moderate to severe COVID-19
symptoms).	
As the examining LHCP, I attest that the above-name	ed student-athlete is now reporting to be completely free of all
signs and symptoms of COVID-19, at least 10 days	from positive test, and afebrile for 24 hours and is either cleared
for resumption of activity or recommended for cardi	ology referral.
☐ Cleared for return to athletics.	
☐ Cleared for return to athletics after completic	on of a graduated return to play due to the severity of symptoms
and/or hospitalization associated with the stu	dent's positive COVID-19 diagnosis.
☐ Not Cleared: Cardiology consultation before	clearance.
Examiner's Signature:	Office Stamp
Examiner's Name Printed:	
Date:	