# Santa Ana Unified School District

## ATHLETICS MEDICAL SCREENING FORM

Last Name:_____ First: _____ DOB:_____ Gender (circle one) Male / Female

Student ID #_____ Grade:_____ Sport(s): _____

**HEALTH HISTORY :** TO BE COMPLETED BY STUDENT-ATHLETE AND PARENT PRIOR TO MEDICAL SCREENING EVALUATION.

| | | |
|---|---|---|
| Head injury, concussion, loss of memory, unconsciousness, persistent headaches | ❒ Yes | ❒ No |
| Bone/joint disorders (broken bones, dislocations, swelling, disease, surgery, arthritis) | ❒ Yes | ❒ No |
| Anemia, leukemia, bleeding disorders | ❒ Yes | ❒ No |
| Kidney/bladder problems | ❒ Yes | ❒ No |
| Eye problems | ❒ Yes | ❒ No |
| Ulcers, stomach trouble | ❒ Yes | ❒ No |
| Heart trouble, heart murmur, high blood pressure, rheumatic fever | ❒ Yes | ❒ No |
| Asthma, tuberculosis, bronchitis | ❒ Yes | ❒ No |
| Ulcers, stomach trouble | ❒ Yes | ❒ No |
| Allergies (Foods, medicines, insects, etc.) | ❒ Yes | ❒ No |
| Seizures, dizzy spells, fainting or convulsions | ❒ Yes | ❒ No |
| Diabetes, hepatitis, jaundice | ❒ Yes | ❒ No |
| Hernia | ❒ Yes | ❒ No |
| Taking medication regularly (If yes, please list medication, dose, and frequency below) | ❒ Yes | ❒ No |
| COVID-19 (If yes please complete second page) | ❒ Yes | ❒ No |

**If yes, please provide details:**

**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: SPECIALIST CLEARANCE/FOLLOW UP REQUIRED |
| MD RECOMMENDATIONS OR RESTRICTIONS: | |

| | | | | | | |
|---|---|---|---|---|---|---|
| BP | HR | HT | 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 | |

**PARENT CONSENT, ACKNOWLEDGEMENT, AND SIGNATURE**

**CONSENT:** By signing below, I hereby give my permission for a screening evaluation.

**ACKNOWLEDGEMENT**: I hereby give my consent for [above named student], hereafter named student, to compete in athletics. I authorize the student to go with and be supervised by a representative of the school on any trips. In case this student becomes ill or is injured, you are authorized to have the student treated and I authorized the medical agency to render treatment. I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under, the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or said hospital it is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the school representative to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. This authorization shall remain effective until the end of the school year unless sooner revoked in writing and delivered to the school.

Parent Signature_____ 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):_____

Date COVID-19 Infection Diagnosed: _____

If symptomatic, date symptoms resolved: _____

COVID Case:

- ☐ Asymptomatic (no symptoms) or mild symptoms (fever, myalgia, chills, and lethargy < 4 days)
- ☐ Moderate symptoms (fever, myalgia, chills or lethargy lasting >=4 days or hospitalized but not in ICU)
- ☐ Severe symptoms (hospitalized in ICU and/or 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-named 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 cardiology referral.

- ☐ Cleared for return to athletics.
- ☐ Cleared for return to athletics after completion of a graduated return to play due to the severity of symptoms and/or hospitalization associated with the student's positive COVID-19 diagnosis.
- ☐ Not Cleared: Cardiology consultation before clearance.

Examiner's Signature:_____ **Office Stamp**

Examiner's Name Printed:_____

Date:_____