



PALISADES CHARTER HIGH SCHOOL

More Than 50 Years of Innovation and Excellence

All Parents/guardians of athletes and all athletes must complete their **Athletic Clearance Online**.

You **MUST upload a completed copy of the PCHS physical form** into athletic clearance for the nurse to clear your physical. No hard copies will be accepted.

Please turn in Emergency Cards directly to your coach.

Registration is at www.athleticclearance.com

Athletes must complete the **online registration process** and upload a copy of your child's most recent physical (must be current and not expire in season).

Video tutorial for online registration:

<https://cartyws.wistia.com/medias/auqpoq4kv6>

MAKE SURE YOUR PHYSICAL EXAM IS CURRENT (Must not expire in season), STAMPED, AND SIGNED BY YOUR PHYSICIAN ONLY (Retain a copy of your athlete's physical for your records)

CHECK FOR ALL **SIGNATURES, DATES, VISION, BLOOD PRESSURE** AND BOXES ARE COMPLETE.

MAKE A PHOTO COPY OF YOUR PHYSICAL EXAM TO KEEP FOR YOUR RECORDS.

INCOMPLETE FORMS WILL PROHIBIT YOUR PARTICIPATION IN ANY SPORTS.

PLEASE VISIT OUR ATHLETIC WEBSITE TO DOWNLOAD THE PARENT STUDENT HANDBOOK AND REVIEW WITH YOUR ATHLETE.

DEPENDING ON VOLUME THE PROCESS TO BE CLEARED MAY TAKE UP TO 10 SCHOOL DAYS.

Sport Pre-participation Physical Examination and Health History

School Year: _____

Last Name: _____ First: _____ MI _____ DOB: _____ Grade: _____ Sport(s): _____

Address/City/Zip: _____ Parent Phone: _____

Health History (completed by student & parent prior to physical exam): explain „YES“ answers; be specific, include approx. dates, current status

Heart Trouble	Yes	No	Asthma-must complete PCHS medication form	Yes	No	Diabetes	Yes	No	Seizures	Yes	No
Palpitations	Yes	No	Fatigue	Yes	No	High Blood Pressure	Yes	No	Kidney conditions	Yes	No
Chest pain	Yes	No	Dizzy/fainting	Yes	No	Extreme shortness of breath/wheezing	Yes	No	Current skin condition	Yes	No
Family member w heart attack < 50 yrs of age, sudden death	Yes	No	Glasses, contacts, protective equipment, hearing aid	Yes	No	Head trauma, concussion, loss of consciousness	Yes	No	Family history of Marfan syndrome or sickle cell	Yes	No
Any allergies	Yes	No	Any injuries or fractures	Yes	No	Any surgeries or hospitalizations	Yes	No	Any other chronic condition	Yes	No

Parent & student confirm that all of this information is correct and has been reviewed with the doctor during the examination.

List all medications for health conditions: _____

List all allergies (give reactions & meds) and/or asthma triggers: _____

Explain “YES” answers: _____

Student Signature

Date

Parent Signature

Date

PHYSICAL EXAMINATION and review of HEALTH HISTORY (completed by the physician)

Distance Vision: R 20/	L 20/	corrected: Y	N	HT:	WT:	BMI/%	BP:	Pulse:	
Appearance				Normal	Musculoskeletal				Normal
Eyes/Ears/Nose/Throat					Neck				
Neck					Spine				
Cardiovascular					Shoulders/arms				
EKG results if done					Elbows/forearms				
Chest & Lungs					Wrist/hands				
Abdomen					Hips/thigh				
Skin					Knees				
Neuromuscular					Legs/ankles				
					Feet				

Diagnosed Chronic Conditions: _____

() Cleared - Full Activity () Cleared – No management of chronic condition required during school or school sports

() Cleared - Chronic condition management required during school & school sports for _____ Medication: (use Pali med form)

() Cleared with restrictions/end date: _____

() Cleared after proof of evaluation or rehab for: _____

() Not cleared/reason: _____

Comments: _____



Physician Name _____ Physician’s Original Signature: _____ Exam Date: _____

Palisades Charter High School
Request For Any OTC or RX Medication To Be Taken At School
PCHS Health Office (HO): 310 230-7218 Fax: 310 230-7246

I. Section To Be Completed By Parent:

Student's Last Name	First Name	DOB	School Year	GR	Sport(s)
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- I understand I must provide any over-the-counter (OTC) or prescription (RX) medications as prescribed by doctor:
 - In its original container with proper labels; over-the-counter or prescription.
 - An updated doctor's order if there is a change in dosage, schedule or health status.
 - Student may not carry OTC or RX medications, except Health Office (HO) approved.
 - Parent must pick up unused medications by last day of school, if not; the medications will be disposed of properly.
- With doctor's orders and HO approval, my student may carry and self-administer without adult supervision but must follow MD orders. School Nurse must authorize any request to carry meds, i.e.: inhalers, epipen, insulin. I understand, accept there is no direct monitoring; student must alert staff for help. PCHS not responsible for any risk involved with improper use including: overuse, improper administration, breakage, theft, or loss. Health Office and/or Dean of Discipline will rescind consent if found to be sharing, playing or being careless with this medication.
 - Back-up meds in HO? Y/N . Health Office Approval to carry: _____
- **List All Triggers of:**
Allergies SEVERE: _____

Allergies MILD/MODERATE: _____

List Triggers of Asthma: _____
- I consent to the PCHS School Nurse (or designee) communicating with the physician.
- I acknowledge that School Nurse (or designee) must authorize this order; student is given copy of orders when ok'd.

Print Parent Name	Signature	Date	Phone(s)	E-mail
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II. Section To Be Completed By Physician:

Medication	Purpose/Diagnosis	Dosage	Time at School Or Frequency	End Date

Special instructions, side effects, recommending HO back-up supply? _____

___ May repeat rescue inhaler every 20 minutes times (___), call parent, then 911 if needed Yes ___ No ___ I agree this student may carry inhaler, is capable and responsible.

Physician Printed Name/	Signature	Date
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Physician Stamp Required