

Los Alamitos Unified School District

Co-Curricular Activity Medical Clearance / Emergency Treatment / Medications Administration

School Year: 2018-2019

Name Last First Initial Birth Date School Los Alamitos High School Grade Male Female Sport/Activity

Home Address City Zip Home Phone Father's Work Mother's Work Father's Cell / Pager Mother's Cell/Pager

If parent cannot be reached contact:

Name City Relationship Phone

Name City Relationship Phone

Student's Physician Address City Phone

Health Insurance Policy# Name of Insured (Including Myers-Stevens/Great Republic/MediCal) (Required by law)

Authorization for Treatment

I/We, the undersigned parent(s), or guardians(s), of the above-named student-athlete of Los Alamitos High School, do hereby consent, in advance, to any X-ray, examination, anesthetic, medical or surgical diagnosis, or treatment (Medical or Dental) which is deemed advisable by, and is to be rendered either by or under the direction of, any available physician(s) (holding a license to practice in the state of California), whether such activity is performed at the school, at the doctor's office, at the hospital, or other place, when such medical service is necessitated by the student-athlete's participation in the school's athletic program. It is understood that this authorization I given in advance of such X-ray, examination, diagnosis or treatment and that neither the school,, nor any school representatives, nor the physician involved, assumes any financial responsibility for exercising this action. It is understood that effort shall be made to contact the undersigned prior to rendering treatment but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions to the above This authorization shall remain effective for this current school year -- September 1 through August 31.

Declaration for Mandatory Medical/Hospitalization Insurance for Athletics

I/We understand that Education Code 32221 requires that a member of a school athletic team, a student selected by the school to directly assist in the conduct of an athletic event or students participating in specified co-curricular activities must have at least \$1,500 hospitalization and medical insurance coverage.

Parent / Guardian Signature Date

Parent Email Student Email

PLEASE KEEP A COPY FOR YOUR RECORDS

Birth Date: _____

Last First Initial

School Year: 2018-2019

Does your child have any of the following? Allergies _____

Life Threatening? Yes No Benadryl needed? Yes No EpiPen Needed Yes No

Diabetes Insulin Pump Yes No Glucagon Yes No

Extra Snacks Yes No Seizures Asthma Inhaler Needed Yes No

Headaches Menstrual Cramps Pain medication needed for these? Yes No

Other Medication that we should be aware of _____

Any special Instructions: _____

Medication for Co-curricular Activities (Only medication listed here may be carried by the student and taken during school-sponsored co-curricular activities. A copy of these orders must be carried with the medication at all times – a Xerox copy is acceptable.)

Name of Medication Dose Frequency Reason for Medication

(Controlled substances such as Ritalin, Adderall, etc must be carried and administered by a school-designated adult.)

I, _____ have read the medication procedure and agree to follow it. I will carry only the medication listed above, in an appropriately labeled container. I will take any medication responsibly and will keep it in my activity bag. I WILL NOT SHARE IT OR GIVE IT TO ANY OTHER STUDENT OR INDIVIDUAL. I understand that I will lose the privilege of carrying medication and self administering my medication if there is any incidence of misuse or abuse.

Student Signature _____ Date _____

Parent Signature _____ Date _____

Medical Clearance

- I have examined the above-named student and feel that he/she is physically capable of participating in competitive interscholastic athletics.
- The medication listed above, with the exception of controlled substances, is to be carried by the student for administration during co-curricular activities.

Physician's Signature _____ Medical License Number _____ Date _____

Physician's Office Stamp (MANDATORY)

(Physician's signature needed for all medication orders and sports physical clearance. Not necessary for field trips.)