



OAK PARK HIGH SCHOOL SPORTS PHYSICALS FUNDRAISER

\$35 per athlete

(a portion of the fee will be donated back to OPHS Athletic Boosters)

Available thru June 8th

**** For incoming 8th grade students, please note that summer conditioning clearance will be on June 4th and 5th so have this completed before clearance.**

Physicals are required for all high school sports. It is best to get physicals at the end of May or early June so the physical is good for one calendar year and will then take your student through all the sports' seasons. Please remember to take the **OPHS athletic physical form** with you to Wellnessmart, MD and have it signed and dated so you can bring it back to the OPHS office at the time of clearance.

LOCATION: Wellnessmart, MD

141 Duesenberg Drive, Ste 3

Westlake Village, CA 91362

Ph: (805) 496-7148

to@wellnessmart.com

OPEN 7 DAYS

M-F - 9am-7pm

Sat - 10am-4pm

Sun - 11am-4pm

NO APPOINTMENT NECESSARY! SAME DAY APPOINTMENTS ARE AVAILABLE.

Be sure to bring in this flyer and mention OPHS!

Thank you for your support. Any questions please contact Loretta Brown at savania@mac.com or Wellnessmart at to@wellnessmart.com

For more information about the facility please check out their website:

<http://www.wellnessmart.com/sports-physicals/>



**OAK PARK HIGH SCHOOL
899 NORTH KANAN RD.
OAK PARK, CA 91377
ATHLETIC PHYSICAL ACTIVITY CERTIFICATE**



Student's Name _____ Grade _____

Sport _____

Address _____ Home Phone _____

Work Phone _____ Emergency Phone _____

Parent or Guardian's Consent

I hereby give my consent for the above-named student to compete in Oak Park High School's approved activity program (athletics, cheerleading etc.) and travel with the school representative(s) on authorized school trips. It is understood that the school district, the student body and/or any of the employees are not financially responsible in case of accident or injury. Each parent may be assured, however, that prudent precaution will be taken to protect the student. The undersigned agrees to be responsible for the safe return of all equipment issued by the school to the above-named student. Failure will result in full replacement costs being collected for any and all such equipment not returned.

Consent for Emergency Treatment

I hereby give my permission to a physician to administer emergency treatment to the above-named student.

Insurance Certification

I hereby certify that the above-named student is covered by accident insurance, which provides protection for accidental bodily injury and for accidental death as required by Education Code Sections 32220-24 for participation in approved school activities during the present school year. Private insurance plans must provide the following minimum coverage:

1. Protection for medical and hospital expenses resulting from accidental bodily injuries in one of the following amounts.
 - a. A group or individual medical plan with accidental benefits of at least \$200 dollars for each occurrence and major medical coverage for at least \$10,000 with no more than \$100 deductible and no less than 80% payable for each occurrence.
 - b. Group or individual medical plans which are certified by the insurance commissioner to be equivalent to the required coverage of at least \$1500.
 - c. At least \$1500 for all such medical and hospital expenses.
2. The insurance required is issued by an admitted insurer, or through a benefit and relief association described in subparagraph (A) of subdivision (3) of section 10493 of the insurance code.

Private/Group Insurance Plan

Name & Address of Insurance Company

Policy Number _____ Expiration Date _____

I have fully read and understand all above items and affix my signature to certify name.

SIGNATURE OF PARENT OR GUARDIAN _____ **DATE** _____

**HEALTH HISTORY
(To be filled out and signed by parent)**

Has your child, _____ ever had or now have:

Yes	No	(Check Each Item)	Yes	No	(Check Each Item)	Yes	No	(Check Each Item)
_____	_____	Allergy	_____	_____	Arthritis	_____	_____	Asthma
_____	_____	Chicken Pox	_____	_____	Concussion	_____	_____	Diabetes
_____	_____	Emotional Problems	_____	_____	Epilepsy	_____	_____	Fainting
_____	_____	Glasses/Contacts	_____	_____	Heart Murmur	_____	_____	Hepatitis
_____	_____	Kidney Trouble	_____	_____	Measles	_____	_____	Menstr. Cramps
_____	_____	Migraine Headaches	_____	_____	Mononucleosis	_____	_____	Mumps
_____	_____	Pneumonia	_____	_____	Polio	_____	_____	Rheumatic Fever
_____	_____	Sinus Trouble	_____	_____	Tuberculosis	_____	_____	Whooping Cough
_____	_____	Other	_____	_____	Other	_____	_____	Other

Operations _____ Nature _____ Year _____

Fractures _____ Nature _____ Year _____

Sprains/Dislocations _____ Nature _____ Year _____

If student has had prolonged absences from school, state when and why:

Allergic to food/medicine _____

Is student now under medical treatment? _____ Why _____

Sports from which student is to be excluded _____

Dates of last: Tetanus Booster _____ Chest X-ray _____ Smallpox Vac. _____

California Interscholastic Federation Physical Examination Summary

(To be filled out and signed by examining physician)

Ht. _____	Wt. _____	Eyes: L _____ R _____	Blood Pressure _____ / _____	Normal ()
Eyes: Sclera _____			Corneas _____	()
Ears: Canals _____			TM's _____	()
Nose: Septum _____			Mucosa _____	()
Throat: Tonsils _____			Teeth _____	()
Cardiovascular: Murmur _____ ()				
			Pulses _____ ()	
Respiratory _____				()
Abdomen: Organs _____			Masses _____	()
Genitalia: Testes _____			Hernia _____	()
			Urine _____	()
Musculoskeletal _____				()
Neurological: DTR's _____				()
Strength & Coordination _____				()

I hereby certify that I have on this date examined the above student and that I have found no medical reason to disqualify him/her from participating in supervised athletics **NOT CROSSED OUT BELOW.**

Baseball	Cross Country	Golf	Softball	Tennis	Volleyball
Basketball	Football	Soccer	Swimming	Track	Cheerleading/Dance

_____ Date _____
Name of Physician (please print)

Signature of examining physician

Please note: Physicals done by school doctor at the annual school-wide physical date are not to replace your regular annual check-up with your primary-care physician.