



Kastner Online Sports Physical

2024/2025

Sport Physicals Are Accepted Online Only

Please scan and follow instructions.

Step 1: Scan QR code or VISIT homecampus.com. Click for PARENTS & STUDENTS. Select CA. Step 2:

Select START CLEARANCE HERE. Type in KASTNER. Confirm school address.

PARTICIPATING in MULTIPLE SPORTS? Use Add New Sport button.

Step 3: COMPLETE ALL REQUIRED FIELDS

Student information, Parent/Guardian Info, Medical History, Signature form, CUSD Pre-Participation Screening form signed by a doctor, take a picture with cell phone and UPLOAD BOTH SIDES.

Step 4: Click SUBMIT COMPLETED APPLICATION

Step 5: Look for a E-mail when the school has CLEARED the student to play!



SCAN ME

Scan the code

today

BEFORE YOU

PLAY

Have Questions? Contact us:

Kastner Athletics | 559.327.2503 | Kastner.cusd.com

Sports Physicals must be completed BEFORE a student athlete can try-out or practice with any team. Physicals cannot expire during the season of participation and will not be accepted for try-outs.

Health Center provided by Clovis Unified School District:

****Free for CUSD Employees Children who attend CUSD schools****

\$ 30.00 for CUSD STUDENTS - Cash & Credit Cards accepted

Sierra Vista Children's Health Center

559-327-7976

M-Th 8:30 - 4:00pm

510 Barstow Ave, Clovis

(The Sierra Vista Children's Health Center is at the southeast corner of the campus, - Barstow & Pollasky- on the Pollasky side behind the Head Start preschool building. Please park in the Pollasky side parking lot and look for the building at the southern end of campus.)

PHYSICAL FORMS MUST BE UPLOADED INTO HOME CAMPUS ALONG WITH HEALTH SCREENING FORM.

Please do not mail or fax form to the school!!

Physicals that expire DURING a season of sport will not be accepted to participate (Practice or compete) on an Athletic team.

All Students wishing to participate in the athletic programs at Kastner Intermediate and Clovis West High School must have "clearance" from the Athletic Department.

Step 1: Complete the ATHLETIC packet and submit it online from the above link.

Step 2: Complete the entire packet - Health Screening/Physical, residence questionnaire, signature page/acknowledgement of policies, rules and guidelines and athletic trainer medical history/contact form.

Step3: Download the actual physical form and take to your doctor to be completed. Once completed, upload the form and turn in with Health Screening form on Home Campus. Do not fax, mail, email, give to your coach or turn into the front office.

Step 4: The Athletic Department will notify your child's head coach when they are cleared to participate in the athletic programs at Kastner.

They will not be allowed to practice or play until they are cleared by the Athletic Department.

CLOVIS USD SPORTS PRE-PARTICIPATION SCREENING FORM A

This form MUST be completed for every sports participant with parent & athlete signature

Student's Name _____ Sex M or F Date of Birth _____

Height: _____ Weight: _____ BMI: _____ Pulse: _____ BP: ____/____

Vision: Grossly Intact _____ Corrected: Y or N Pupils: Equal _____ Unequal _____

Physical Screening	Normal Findings	X	Abnormal Findings	No Exam
Appearance	WDWN			
Eyes/Ears/Nose/Throat	WNL			
Lymph Nodes	WNL			
Hearing	Grossly Intact			
Heart	RRR, No Significant Murmur			
Pulses	WNL			
Lungs	Clear/equal			
Abdomen	Soft, No HSMT			
Skin	Warm/Dry/Intact			
Neck	FROM			
Back	No Scoliosis			
Shoulder/Arm/Elbow	FROM, = strength			
Forearm/Wrist/Hand	FROM, = grip/strength			
Hip/Thigh/Knee	FROM			
Leg/Ankle/Foot	FROM			
Hernia/Squat/Duck Walk	WNL			
Immunizations given				

CLEARANCE

- Cleared
- NOT** Cleared until completed evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Health Care Provider (print/type/stamp): _____ Date of exam: _____

Address: _____ Phone: _____

Signature of Health Care Provider: _____ Date of signature: _____

This form was developed based upon guidelines from the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Sports Medicine, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine and the American Academy of Sports Medicine, 2009.

CLOVIS USD SPORTS PRE-PARTICIPATION SCREENING FORM B

This form MUST be completed for every sports participant with parent/guardian & athlete signatures

Student's Name _____ Sex M / F Age _____ Date of Birth _____
 Address _____ Student ID # _____
 Grade _____ School _____ Sport(s) _____
 In case of emergency, contact: Name _____ Relationship _____
 Phone #'s: (H) _____ (W) _____ (C) _____

Explain "YES" answers below. Circle questions you do not know the answer to.

- | | YES | NO | | YES | NO |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do you have any major health conditions? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had a medical illness or injury since your last checkup or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you even been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you cough, wheeze, or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Do you have asthma or use an inhaler?
If "Yes", Do you carry your inhaler while you are playing sports? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you missing an organ or body part? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Do you have diabetes?
If "Yes", do you take insulin? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Do you use any protective or corrective equipment or devices that aren't usually used for your sport or position, such as knee braces, special neck roll, foot orthotics, retainer on your teeth, or hearing aid? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any allergies to medication, food, stinging insects, or pollen? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you ever had a sprain, strain, or swelling after injury, or any problem with pain or swelling in muscles, tendons, bones, or joints?
If "Yes", which locations: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever passed out or nearly passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Have you had any problems with your eyes or vision, wear glasses, contact lenses, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 30. For females: Age at first period: _____
Are periods regular? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Date of last tetanus shot: _____
Tdap date: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | Explain "YES" answers here: _____

_____ | | |
| 12. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 13. Have you had a severe viral infection such as infection of the heart or mononucleosis within the last six months? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 14. Has a doctor ever told you that you have any heart problems?
If so, check all that apply:
<input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart infection
<input type="checkbox"/> High cholesterol <input type="checkbox"/> High blood pressure
<input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 15. Has a doctor ever ordered a test for your heart, such as ECG/EKG (Echocardiogram)? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 16. Do you have any current skin problems such as itching, rashes, acne, warts, fungus, or blisters? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 17. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 18. Have you ever been knocked out, become unconscious or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 19. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 20. Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 21. Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

I hereby state, that to the best of my knowledge, my answers to all the above questions are correct and complete and I take full responsibility for any incorrect answers.

Signature of Athlete _____ Signature of Parent/Guardian _____ Date _____