THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA
1960 LANDINGS BOULEVARD, SARASOTA, FL 34231
PHONE (941) 927-9000

MIDDLE SCHOOL STUDENT ATHLETIC PACKET CHECKLIST FOR 2017-2018

Instructions: The Sarasota County School District Athletic Program must comply with rules, policies, and procedures, set by The School Board of Sarasota County, Florida. Before participating in athletics, this entire packet must be completed and returned to the Head Coach of your athletic sport/Athletic Director's Office. No student is allowed to participate unless all of the necessary information is complete and required signatures are obtained. This packet will be filed in the Athletic Director's office. A new packet must be completed every year.

Student Legal Name (Print) _____ DOB _____
Last First Middle

2016-2017 School Name _____ Grade _____ Sex Male ☐ Female ☐
(where student takes academic classes)

School student will be participating in sports _____ Are you a school choice student? Yes ☐ No ☐

Are you a Home Education student? Yes ☐ No ☐

Home Educations students must contact the middle school Athletic Director 3 weeks prior to the start of season.

Check the season that you want to participate in: _____ Fall _____ Winter _____Spring

Initial box to indicate completion. All forms require both student and parent/guardian signatures. Specified forms require signatures be notarized.

☐ **Pre-Participation Physical Evaluation for Middle School Students** (066-14-DIS)
Page 1 must be signed and dated by the student and the parent/guardian. Page 2 is completed, signed, and dated by the physician. The physical is valid for 365 days from the date of the physician's evaluation. As an alternative, the Florida Department of Health School Entry Health Exam Form (DH3040-CHP-07/2013) may also be used.

☐ **Parent/Guardian Release and Hold Harmless Agreement for Middle School Student Athletic Participation** (027-01-DIS)
Signatures of student and parent/guardian must be notarized.

☐ **Current insurance carrier information** (name of insurance company and policy number) must be included on the above two forms. Insurance is required to try out and participate. If the student athlete is not covered under a family plan, insurance can be purchased online at www.schoolinsuranceofflorida.com. **A copy of the insurance card must be submitted with this packet. If you purchased insurance through School Insurance of Florida on-line, attach the receipt.**

☐ **Acknowledgement of Standards for Participation in Middle School Athletic Activities** (068-14-DIS)

☐ **Authorization to Release Medical Information for Athletics** (062-14-DIS)

☐ **Emergency Medical/Treatment Field Trip Consent** (063-96-DIS)
Include doctor name and contact information on form.

Student Signature _____ Date _____

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date _____

OFFICE USE ONLY

Physical Date _____ Insurance: School Personal GPA _____

School: Home Oak Park PV SMA ECA Other _____

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PRE-PARTICIPATION PHYSICAL EVALUATION FOR MIDDLE SCHOOL STUDENTS

Instructions: This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2. This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.

Part 1. Student Information (to be completed by student or parent).

Student Name _____ Sex ____ Age _____ Date of Birth _____

School _____ Grade _____ Sport(s) _____

Home Address _____ Home Phone _____

Parent/Guardian Name _____ E-mail _____

Person to Contact in Case of Emergency _____ Relationship to Student _____

Home Phone _____ Work Phone _____ Cell Phone _____

Personal/Family Physician Name _____ Office Phone _____

Part 2. Medical History (to be completed by student or parent). Explain "yes" answers below. Circle questions you don't know answers to.

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___
2. Do you have an ongoing chronic illness?	___	___
3. Have you ever been hospitalized overnight?	___	___
4. Have you ever had surgery?	___	___
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	___	___
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	___	___
7. Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)?	___	___
8. Have you ever had a rash or hives develop during or after exercise?	___	___
9. Have you ever passed out during or after exercise?	___	___
10. Have you ever been dizzy during or after exercise?	___	___
11. Have you ever had chest pain during or after exercise?	___	___
12. Do you get tired more quickly than your friends do during exercise?	___	___
13. Have you ever had racing of your heart or skipped heartbeats?	___	___
14. Have you had high blood pressure or high cholesterol?	___	___
15. Have you ever been told you have a heart murmur?	___	___
16. Has any family member or relative died of heart problems or sudden death before age 50?	___	___
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)?	___	___
20. Have you ever had a head injury or concussion?	___	___
21. Have you ever been knocked out, become unconscious or lost your memory?	___	___
22. Have you ever had a seizure?	___	___
23. Do you have frequent or severe headaches?	___	___
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	___	___
25. Have you ever had a stinger, burner or pinched nerve?	___	___
26. Have you ever become ill from exercising in the heat?	___	___
27. Do you cough, wheeze or have trouble breathing during or after activity?	___	___
28. Do you have asthma?	___	___
29. Do you have seasonal allergies that require medical treatment?	___	___
30. Do you use any special protective or corrective equipment or medical devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid)?	___	___
31. Have you had any problems with your eyes or vision?	___	___
32. Do you wear glasses, contacts or protective eyewear?	___	___
33. Have you ever had a sprain, strain or swelling after injury?	___	___
34. Have you broken or fractured any bones or dislocated any joints?	___	___
35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? If yes, check appropriate blank and explain below		
___ Head ___ Elbow ___ Hip		
___ Neck ___ Forearm ___ Thigh		
___ Back ___ Wrist ___ Knee		
___ Chest ___ Hand ___ Shin/Calf		
___ Shoulder ___ Finger ___ Ankle		
___ Upper Arm ___ Foot		
36. Do you want to weigh more or less than you do now?	___	___
37. Do you lose weight regularly to meet weight requirements for your sport?	___	___
38. Do you feel stressed out?	___	___
39. Have you ever been diagnosed with sickle cell anemia?	___	___
40. Have you ever been diagnosed with having the sickle cell trait?	___	___
41. Record the dates of your most recent immunizations (shots) for:		
Tetanus _____ Measles_____		
Hepatitis B _____ Chickenpox _____		
FEMALES ONLY (optional)		
42. When was your first menstrual period? _____		
43. When was your most recent menstrual period? _____		
44. How much time do you usually have from the start of one period to the start of another? _____		
45. How many periods have you had in the last year? _____		
46. What was the longest time between periods in the last year? _____		

Explain "Yes" answers here.

_____

_____

_____

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

_____ _____ _____ _____
Student Signature Date Parent/Guardian Signature Date

RET: Master, ESY, GS7 37
Dupl., OSA

PRE-PARTICIPATION PHYSICAL EVALUATION FOR MIDDLE SCHOOL STUDENTS

Part 3. Physical Examination (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).

Student Name _____ Date of Birth _____

Height _____ Weight _____ % of Body Fat (Optional) _____ Pulse _____ Blood Pressure _____

Temperature _____ Hearing: right: P _____ F _____ left: P _____ F _____

Visual Acuity: Right 20/_____ Left 20/_____ Corrected: ☐ Yes ☐ No Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
1. Appearance			
2. Eyes/Ears/Nose/Throat			
3. Lymph Nodes			
4. Heart			
5. Pulses			
6. Lungs			
7. Abdomen			
8. Genitalia (males only)			
9. Skin			
MUSCULOSKELETAL			
10. Neck			
11. Back			
12. Shoulder/Arm			
13. Elbow/Forearm			
14. Wrist/Hand			
15. Hip/Thigh			
16. Knee			
17. Leg/Ankle			
18. Foot			

*station based examination only

ASSESSMENT OF EXAMINING PHYSICIAN/ASSISTANT/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusions(s).

___ Cleared without limitation

___ Disability _____ Diagnosis _____

_____

___ Precautions _____

_____

___ Not Cleared For _____ Reason _____

_____

___ Cleared after completing evaluation/rehabilitation for _____

___ Referred to _____ For _____

_____

Recommendations _____

_____

_____

_____

Physician/Assistant/Nurse Practitioner Name (Print) _____

Address _____

_____ _____

Physician/Assistant/Nurse Practitioner Signature Date

RET: Master, ESY, GS7 37
Dupl., OSA

PRE-PARTICIPATION PHYSICAL EVALUATION FOR MIDDLE SCHOOL STUDENTS

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (IF APPLICABLE)

Student Name _____ Date of Birth _____

I hereby certify that each examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s).

___ Cleared without limitation

___ Disability _____ Diagnosis _____

_____

___ Precautions _____

_____

___ Not Cleared For _____ Reason _____

_____

___ Cleared after completing evaluation/rehabilitation for _____

Recommendations _____

_____

_____

_____

Physician Name (Print) _____

Address _____

_____ _____

Physician Signature Date

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.

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PARENT/GUARDIAN RELEASE AND HOLD HARMLESS AGREEMENT FOR MIDDLE SCHOOL STUDENT ATHLETIC PARTICIPATION

Instructions: This form must be notarized and returned to the Head Coach/Athletic Director's Office with the Athletic Packet. If you have questions pertaining to this form, contact your child's school.

Student Name (Print) _____ DOB _____

School Name _____ School Year _____

Initial sport/activity this agreement governs _____ Basketball (Grades 6-8) _____ Track (Grades 6-8)

_____ Volleyball (Grades 6-8) _____ Intramurals (Grades 6-8)

Parent/Guardian Home Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

I/We fully understand that playing or practicing to play interscholastic sports may be hazardous and poses a risk of injury, including but not limited to, sprains, strains, contusions, abrasions, broken bones and in extreme cases, paralysis or death. Due to the potential hazards associated with interscholastic sports, I/we recognize the importance of following the instructions of coaches and trainers, regarding playing techniques, training and other rules associated with this sport/activity.

I/We understand that it is the responsibility of the parents/guardians to provide proof of medical insurance coverage prior to participating in any phase of this sport/activity.

☐ YES I/we will be purchasing the student accident insurance made available through the Sarasota School District.

☐ NO I/we have comprehensive medical insurance that covers this student for any expenses he/she may incur as the result of a sports injury.

Name of Insurance Company _____

Policy No. _____ Effective Dates _____

This agreement is entered into voluntarily and is made with the understanding that I/we have not violated any of the eligibility rules and regulations the Sarasota School District. I/we give my/our consent for my/our student/child/ward to engage in Sarasota School District approved athletic activities as a representative of the student's school. I/we give my/our consent for him/her to accompany the team on out of town/county trips.

In consideration of The School Board of Sarasota County, Florida, permitting my/our student/child/ward to engage in interscholastic sports, I/we agree to release and hold harmless The School Board of Sarasota County, Florida, and its employees and agents from and against all claims, judgments, cost, expenses, attorney fees, including but not limited to, claims occurring from the negligence of The School Board of Sarasota County, Florida, its employees, and agents arising out of bodily injuries or property damage resulting from participation in interscholastic sports.

I/We acknowledge that I/we have read this agreement and fully understand its meaning, and that I/we will abide by all terms and conditions associated wit this sport/activity and in this agreement.

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date _____

Student Signature _____ Date _____

STATE OF FLORIDA, SARASOTA COUNTY
Sworn to and subscribed before me this _____ day of _____, 20____, by

_____.

Personally known _____ Produced identification _____ Type of Identification Produced _____

(Seal)

_____
Typed or Printed Name of Notary Public

_____
Signature of Notary Public

My Commission Expires _____ Commission No. _____

RET: Master, 7AY, Ind Sch 62
Dupl., OSA

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ACKNOWLEDGEMENT OF STANDARDS FOR PARTICIPATION IN MIDDLE SCHOOL ATHLETIC ACTIVITIES

Instructions: This form must be signed and returned to the Head Coach/Athletic Director's Office. This form should be filed in the Athletic Director's office. If you have questions pertaining to this form, contact the Athletic Director of your child's school.

Student athletes and parent(s)/guardian(s) must comply with the following standards for athletes and cheerleaders representing The School Board of Sarasota County, Florida. These standards apply to all cheerleading and athletic activities. The School Board of Sarasota County, Florida, maintains high expectations for academic achievement and appropriate behavior. All students must comply with the Sarasota County School District Code of Student Conduct and all school-specific behavior expectations.

To be eligible to play or to participate in either a practice or an event/game, a student must

1. meet all eligibility requirements as set by The School Board of Sarasota County. Included in the rules is the expectation that student athletes maintain a minimum 2.0 cumulative GPA.
2. be present in school for at least one-half (1/2) of the academic day unless excused by an administrator and approved by the Athletic Director.
3. attend required practices prior to an event or game unless excused by a coach, trainer, teacher, or administrator.
4. not have left another sport during that season.

These are the minimum expectations set by the Athletic Department. A Coach/Principal may add additional rules to those listed above that he/she feels are in the best interest of the program.

The following violations will result in immediate suspension from a team:

1. The confirmed use of tobacco or alcohol*
2. The sale or use of any illegal drugs*
3. Being charged with a felony*
4. Failure to adhere to the attendance policy of The School Board of Sarasota County
5. Failure to adhere to the discipline policy of The School Board of Sarasota County
6. Any act of unsportsmanlike conduct at practice or game/event
7. Any act that brings embarrassment to the school

*Automatic suspension for the remainder of the season

By signing below, you acknowledge the rules and responsibilities as specified above.

Student Name (Print) _____ DOB _____

School Name _____

Student Signature _____ Date _____

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR ATHLETICS

Instructions: This form is required to allow Athletic Trainers from Agility Physical Therapy & Sports Performance, LLC. to release protected medical information for student athletes to The School Board of Sarasota County, Florida, coaching staff. This form must be returned to the Head Coach or Athletic Secretary. The original will be given to the Athletic Trainer and a copy will be maintained in the Athletic Director's office. This authorization is not valid unless signed and dated by the athlete or legally authorized representative. If you have questions pertaining to this form, contact the Athletic Director of your child's school.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Agility Physical Therapy & Sports Performance, LLC., is required to provide the patient, the patient's parent, or legally authorized representative with the Notice of Privacy Practices describing how they use and disclose patient health information. If you have not received a copy of the Notice of Privacy Practices, it is available through the Athletic Trainer at your High School.

Authorization of Disclosure

Student Name (Print) _____ DOB _____
Last First Middle

I authorize Agility Physical Therapy & Sports Performance, LLC. to release/disclose the following protected health information from my student athlete records including information regarding my medical condition, injuries, prognosis, diagnosis, athletic participation status, treatment and care information, and related personal identifiable health information. I certify that this authorization has been made voluntarily. This information is to be released/disclosed to the Athletic Director, Team Physician, School Health Professional, or coaching staff for The School Board of Sarasota County, Florida, for the purposes of my care as a student athlete.

Possibility of Re-disclosure
I understand that any information provided under this release may be subject to re-disclosure by the recipient under circumstances no longer protected by state and federal regulations.

Expiration and Revocation
I understand that this authorization is valid for 14 months from the date I sign it. I understand that I have the right to revoke this authorization in writing at any time. The revocation will take effect on the day it is received except to the extent it has already been acted upon.

Conditions of Treatment
I understand that Agility Physical Therapy and Sports Performance cannot condition my treatment upon my signing this authorization.

Acknowledgement of receipt of Notice of Privacy Practices (initial) _____

Student Signature _____ Date _____

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date _____

*Legally Authorized Representative Name (Print) _____

Legally Authorized Representative Signature _____ Date _____

*If other than student athlete signing, state relationship _____

Distribution: Original – Athletic Trainer Copy – Student Athlete File

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PHONE (941) 927-9000

EMERGENCY MEDICAL/TREATMENT CONSENT FOR FIELD TRIPS AND/OR OTHER AFTER SCHOOL ACTIVITIES

Instructions: Return completed form to your child's school. If you have questions pertaining to this form, contact your child's school.

Date _____

Student Name _____ DOB _____
Last First Middle

Home Address _____
Street City Zip

Parent/Guardian Name (Print) _____ Relationship _____

Address of above (if different) _____
Street City Zip

Home Phone _____ Work Phone _____ Cell Phone _____

List a person other than the parent or guardian who could be contacted in case of emergency below:

Emergency Contact Name (Print) _____ Phone _____

Is above student allergic to foods, medications, or insects? ☐ Yes ☐ No

If Yes, list what they are and emergency medication/treatment, if any. _____

_____

_____

Does the above student have any chronic medical problems (such as asthma, diabetes, seizures)? ☐ Yes ☐ No

If Yes, list and describe medical requirements for field trip _____

_____

Does the above student take any daily medication(s)? ☐ Yes ☐ No

If Yes, complete the medication treatment authorization form (if not previously on file in the school Health Room) and list the medication(s) and time to be administered _____

_____

Family Physician Name (Print) _____ Physician Phone _____

In case of non-life threatening emergency, list hospital preference _____

In case of serious illness or injury where immediate care is needed, the school or its representative has my permission to contact the appropriate emergency medical service. The emergency medical service has my consent to provide necessary treatment or transportation for my child. I then request that I be notified of the situation. The undersigned will be responsible for emergency treatment cost.

In the case of an accident or illness where immediate treatment of my child is not indicated, but where (s)he is unable to remain at the field trip, I request that the school contact me or my designee to arrange transportation for my child. If the school is unable to contact me, I request that the other person listed on this form be contacted and requested to care for my child.

I understand that I must notify the school in writing if there are any changes in this health emergency information. I understand that this statement remains in effect until the end of this school year unless revised or cancelled by me in writing to the school.

Parent/Guardian Signature _____ Date _____

Distribution: Original – Office Yellow – Teacher