SCHOOL BOARD OF ST. LUCIE COUNTY, FLORIDA
MIDDLE SCHOOL INTRAMURAL, PERMISSION, AND RELEASE

Name of Student Participant (Please print) _____

Home Address _____

Home Phone _____ Date of Birth _____ Place of Birth _____

Parent/Guardian Work Phone _____ Other Emergency /Cell Phone _____

School _____ Grade Level _____ Sport(s) _____

I/We, the undersigned Parent(s)/Guardian(s) of the above named student, acknowledge that participating in middle school intramurals in the St. Lucie County Schools is entirely voluntary and subject to the rules and policies of the St. Lucie County School District. I understand that my child must abide by all the rules set down by the School Board of St. Lucie County and the school in which the Student Participant is enrolled (School). All infractions of the Code of Student Conduct shall be reported to school administration. All infractions are subject to the appropriate Discipline Response as defined in The School Board of St. Lucie County Code of Student Conduct.

Student participants and parents or guardians of Student participants should have a thorough understanding of the responsibilities and implications of participating in a voluntary extracurricular activity. For this reason, each Student Participant in the St. Lucie County Schools and his/her parent(s), or guardian(s), shall read, and sign this agreement, permission, and release prior to the Student Participant being allowed to participate in any form of intramural practice or contests.

I/We, the undersigned Parent(s)/guardian(s) of the above named Student Participant:

1. Understand that I must have a current physical on file at the school and a completed permission and release form.

2. Understand that only a supplementary insurance premium for the Student Participant is to be paid from school board funds. This insurance will have a **$500.00** deductible. This deductible will be applied concurrent with primary coverage which will be paid at 100% Reasonable and Customary. If there is no primary coverage, this insurance will pay 100% of Reasonable and Customary after the **$500.00** deductible.

3. Understand that a **TWENTY DOLLAR ($20.00) NON-REFUNDABLE PROCESSING FEE must be paid when this form is submitted.** This fee does guarantee participation in the Intramural program at the school your child attends; **however it does not guarantee selection to a tournament team.** I also understand that additional fees may be assessed to participate in a specific sport due to financial limitations and the uncertainty of financial times.

4. Understand that in the event of accident or injury, only School required accident forms will be completed by School officials, and that all claims under any applicable insurance policy for injuries received while participating in intramural activities or travel incidental to such activities shall be processed by the Parent(s)/guardian(s) or the student participant through the company agent handling the insurance policy, and **not** through School officials.

5.. Authorize the School to transport the Student Participant and to obtain, through a physician of the School's choice, any emergency medical care that may become reasonably necessary for the student in the course of intramural activities or travel incidental to such activities; and agree that the expenses for such transportation and treatment shall not be borne by the School Board or its employees.

6. I understand that talking to a coach or someone from any high school about playing at his/her school before you begin attending that school is a violation and could result in: (FHSAA Policy 36)

- **a. You being ineligible for a year;**
- **b. The coach may be fined and suspended;**
- **c. The school may face penalties including fines and not making the playoffs.**

NOTICE TO PARENTS/GUARDIANS OF MINOR CHILD PARTICIPANTS

READ THIS FORM COMPLETELY AND CAREFULLY. YOU ARE AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF THE SCHOOL DISTRICT OF ST. LUCIE COUNTY, ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS USE REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM ST. LUCIE COUNTY SCHOOL DISTRICT IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH, TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND THE ST. LUCIE COUNTY SCHOOL DISTRICT HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

I/WE, THE UNDERSIGNED PARENT(S) AND STUDENT PARTICIPANT ACKNOWLEDGE HAVING RECEIVED AN ADEQUATE OPPORTUNITY TO REVIEW THIS AGREEMENT, PERMISSION, AND RELEASE AND TO ASK QUESTIONS OF SCHOOL OFFICIALS. I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AGREEMENT; THAT I AGREE TO ITS TERMS; THAT I WILL COMPLY WITH ALL SCHOOL BOARD AND STATE ASSOCIATION RULES. IT IS UNDERSTOOD THAT THE STUDENT ATHLETE IS REQUIRED TO COMPLY WITH ALL SAFETY RULES AND INSTRUCTIONS PROVIDED WITH EACH SPORT, COMPETITION, AND PRACTICE WHILE ENGAGING IN SUCH ACTIVITIES.

I/WE UNDERSTAND THAT PARTICIPATION IN INTERSCHOLASTIC ATHLETICS IS A PRIVILEGE. FURTHERMORE, WE/I UNDERSTAND THAT THE PRINCIPAL OR DESIGNEE HAS THE SOLE DISCRETION TO WITHDRAW MY ELIGIBILITY AT ANY TIME DUE TO AN ON-CAMPUS OR OFF-CAMPUS BEHAVIOR THAT IS DEEMED BY THE PRINCIPAL OR DESIGNEE TO BE UNBECOMING OF A STUDENT ATHLETE.

----------**Acknowledgment of Parent/Guardian Signature)**----------

Print Parent/Guardian Name _____ Date _____

Sign Parent/Guardian Name (In presence of Notary) _____

STATE OF FLORIDA
COUNTY OF ST. LUCIE

The foregoing instrument was acknowledged before me this _____ day of _____, _____, by _____. He/She is ___ personally known to me, or ___ has produced _____ as identification, and ___ did ___ did not take an oath.

(Notary Seal) My Commission Expires _____

Notary Public State of Florida _____

Print Notary Name _____

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Revised 03/16

Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 1 of 3)

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's Name: _____ Sex: ____ Age: ____ Date of Birth: ____/____/____

School: _____ Grade in School: ____ Sport(s): _____

Home Address: _____ Home Phone: (____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____

Relationship to Student: _____ Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Personal/Family Physician: _____ City/State: _____ 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?	____	____
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?	____	____

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	

41. Record the dates of your most recent immunizations (shots) for:
    Tetanus: _____ Measles: _____
    Hepatitus 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, and FHSAA Bylaw 9.7, 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.

Signature of Student: _____ Date: ___/___/___ Signature of Parent/Guardian: _____ Date: ___/___/___

Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 2 of 3)

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.
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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's Name: _____ Date of Birth: ____/____/____

Height: _____ Weight: _____ % 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/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 conclusion(s):

____ Cleared without limitation

____ Disability: _____ Diagnosis: _____

____ Precautions: _____

____ Not cleared for: _____ Reason: _____

____ Cleared after completing evaluation/rehabilitation for: _____

____ Referred to _____ For: _____

Recommendations: _____

Name of Physician/Physician Assistant/Nurse Practitioner (print): _____ Date: ____/____/____

Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____

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Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 3 of 3)

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.
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Student's Name: _____

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the 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: _____

Name of Physician (print): _____ Date: ___/___/_____

Address: _____

Signature of Physician: _____

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