



THE SCHOOL DISTRICT OF PALM BEACH COUNTY
DEPARTMENT OF SECONDARY CURRICULUM

Athletic Eligibility for Middle School Students

Parents, in order for your son or daughter to be eligible to participate in athletics at his/her middle school during the upcoming school year, you and your son or daughter must complete this form and sign where indicated. **Make sure you read each page carefully before signing!** A parent or the student (if an adult or emancipated) needs to sign in front of a notary. We **cannot** notarize any papers if they come to us already signed.

| | | | | | | |
|---|-----------------------------|-------------|---|-------------------------------------|------------------------|------|
| Student Name (first, mi, last) | | | | Student ID# | School Year ▼ | Date |
| Birth Date | Age | Gender ▼ | Current Grade ▼ | Name of Parent/Legal Guardian | | |
| Student Address (street, apt. #, city, state, zip code) | | | | | Student Phone # | |
| First School Attended This Year | | | School(s) Attended Last Year | | | |
| Name of Emergency Contact | | | | Relationship to Student | | |
| Emergency Contact Address (street, apt. #, city, state, zip code) | | | | | Emergency Home Phone # | |
| Emergency Work # | Name of Student's Physician | | | | Physician Phone # | |
| List Sports | | | | | | |
| PROOF OF INSURANCE FOR STUDENT | | | | | | |
| Name of Medical Insurance Company (policy that covers student) | | | | | Insurance Policy # | |
| Name of Policy Holder (policy that covers student) | | | Policy Holder's Relationship to Student | Policy Holder's Place of Employment | | |
| ATHLETIC ELIGIBILITY REQUIREMENTS FOR MIDDLE SCHOOL STUDENTS | | | | | | |

TRANSFER STUDENTS AND NEW STUDENTS must have transcripts* on file before an athlete is eligible to participate.

ALL STUDENT OBLIGATIONS must be met before participation in athletics/activities is allowed.

ALL SECTIONS OF THIS FORM must be filled out, signed and **MUST BE ON FILE** in Athletic Director's Office ten days prior to the first contest.

ALL STUDENTS MUST HAVE a Birth Certificate* on file in the Athletic Office.

A STUDENT WHO HAS ATTAINED THE AGE OF 15 prior to September 1st of the current school year may submit a hardship waiver to the school's Athletic Director to be considered for participation.

ALL STUDENTS MUST SHOW proof of insurance coverage or purchase student accident insurance which will provide minimal medical reimbursement. The School District is NOT responsible for accidental interscholastic athletic injuries.

A STUDENT MAY participate for three consecutive years from the time he/she first successfully completes the fifth grade.

FAILURE IN MORE THAN ONE (1) SUBJECT during a given 9 week grading period shall cause a student to be ineligible for practice and competition the following 9 week grading period. An "I" incomplete will be considered the same as an "F" until it is replaced with a valid grade. In addition, a student must maintain a specified grade point average of 2.0 as well as acceptable conduct for the previous 9 week period to be eligible. Grades earned in summer school will be calculated to determine the courses passed during the previous term. Grades for courses taken in summer school will be calculated with grades for the last marking period of the previous year to determine eligibility. Student must maintain satisfactory conduct. (S.B. Policy 5.60)

** If specific documentation requested is not available, contact the athletic director for further instruction.*

| | | |
|--|---|-----------------------------|
| School Conniston Middle School | Athletic Director V. Quaranta | Telephone # 561-802-5400 |
|--|---|-----------------------------|

INTERSCHOLASTIC ELIGIBILITY RESIDENCE AFFIDAVIT



I live with (check one) Both Parents Mother Only Father Only Guardian Other _____

Relationship to other _____ I have lived with the person(s) stated above since _____

If the options presented below do not adequately describe your residence situation, attach a note of explanation.

- I live in the assigned attendance area for this school. I have been accepted into a Choice Program.
- I am attending this school on an approved student reassignment (reassignment requires approval by the Reassignment Specialist).
- I have been assigned to this school by the Department of Exceptional Student Education.

CONSENT AND RELEASE OF LIABILITY CERTIFICATE - READ CAREFULLY BEFORE SIGNING

I (the student) and we (the parent[s]/legal guardian[s]) have read the (condensed) Florida High School Activities Association (FHSAA) Eligibility Rules and understand that they are a synopsis of the FHSAA By Laws. I/we also understand that a complete copy of the FHSAA By Laws is available to me/us to review at my (the student's) school's administrative office. We know of no reason why I (the student) am not eligible to represent my school in athletic competition. If accepted as a representative, we agree to follow the rules of my school and the FHSAA and to abide by their decisions. I/we know that participation is a privilege. I/we have been informed and know of the risks involved in athletic participation, understand that serious injury, and even death, is possible in such participation and choose to accept such risks. I (the student) voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved. I/we hold harmless and release the student's school, the school district's employees and agents, the schools against which it competes, the Palm Beach County School Board and the contest officials, the National Federation of State High School Associations, (NFHS) and the FHSAA of any and all responsibility and liability for any injury or claim resulting from such athletic participation, and agree to take no legal action against any of the above-referenced entities because of any accident or mishap involving the student's athletic participation. I/we further authorize **EMERGENCY MEDICAL TREATMENT** for myself/our child/ward should the need arise for such treatment while I am/my child/ward is under the supervision of the school. **In consideration for being allowed to participate in Interscholastic Athletic programs, I/we, for my/our heirs, executors and administrators, release and forever discharge THE SCHOOL BOARD OF PALM BEACH COUNTY, FLORIDA, its agents, representatives and employees of all liability, claims, actions, damages, costs or expenses which I/we may have against them arising out of or in any way connected with my (the student's) participation in an Interscholastic Athletic program, including travel associated with the Athletic Program. I/we understand that this waiver includes any claims based on negligence, action or inaction of any of the above named entities and persons.** I/we hereby give permission for the school or District to use the student photograph, video image, writing, voice recording, name, grade level, school name, description of participation and statistics in officially recognized activities and sports, weight and height as a member of an athletic team, dates of attendance, diplomas and awards received, date and place of birth and most recent previous school attended, in newspapers, school productions, web sites, etc. and/or similar school or District-sponsored publications or in school or District-approved news media interviews, videos, articles and photographs. The released parties, however, are under no obligation to exercise said rights herein. I/we hereby give consent for my/our child/ward to participate in the following interscholastic sports that I/we have NOT MARKED OUT. Sports: Baseball, Basketball, Soccer, Fast-Pitch Softball, Track & Field, Volleyball.

Other sports added to form by school:

I/we understand that participation may necessitate an early dismissal from classes. I/We consent to the disclosure, by my/our child's/ward's school, to the FHSAA, upon its request, of all detailed (athletic or otherwise) financial, scholastic and attendance records of such school concerning my/our child/ward.



THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Student Medical Consent for Athletics

Print Student Name _____ Birth Date _____

The student, hereby known as patient, and parent(s) or legal guardian(s) whose signatures are attached below do hereby consent to any and all emergency medical and/or surgical treatment including anesthesia and operations which may be advisable by the patient's physicians and/or surgeons. The intention hereof being to grant authority to administer and perform all and singularly examinations, treatments, anesthetics, operations and diagnostic procedures which may be deemed advisable or necessary. We also agree that the patient, when admitted, is to remain in the hospital until his or her physician recommends that the patient is discharged. (Attach any additional pages, if needed, including any relevant provisions in student's IEP or 504 plan.) In the event of an emergency, reasonable attempts will be made to contact the parent. This would not prevent the emergency health care provider from acting in the best interests of the child.

In witness of our consent and agreement to the matters stated in the preceding sentences, we have subscribed our signatures below:



Signature of Student _____ *Date*

Signature of Parent/Guardian _____ *Date*

Signature of Parent/Guardian _____ *Date*

Telephone or cell number to call in case of emergency

NOTARY OF PARENT'S/LEGAL GUARDIAN'S OR ADULT/EMANCIPATED STUDENT'S SIGNATURE

STATE OF FLORIDA

COUNTY OF _____

Sworn to or affirmed and subscribed before me this _____ day of _____, _____,

by _____.

(parent/guardian or adult/emancipated student)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

Signature of Notary Public - State of Florida

MUST BE NOTARIZED!

Must Get a Sports Physical



PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/23

MEDICAL HISTORY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ____/____/____
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ City/State: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____ Relationship to Student: _____
 Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
 Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

List past and current medical conditions:

Have you ever had surgery? If yes, please list all surgical procedures and dates:

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

Patient Health Questionnaire version 4 (PHQ-4)

Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)

| | Not at all | Several days | Over half of the days | Nearly everyday |
|---|------------|--------------|-----------------------|-----------------|
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

| GENERAL QUESTIONS | | Yes | No | HEART HEALTH QUESTIONS ABOUT YOU | | Yes | No |
|--|--|-----|----|--|---|-----|----|
| Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer. | | | | <i>(continued)</i> | | | |
| 1 | Do you have any concerns that you would like to discuss with your provider? | | | 8 | Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)? | | |
| 2 | Has a provider ever denied or restricted your participation in sports for any reason? | | | 9 | Do you get light-headed or feel shorter of breath than your friends during exercise? | | |
| 3 | Do you have any ongoing medical issues or recent illnesses? | | | 10 | Have you ever had a seizure? | | |
| HEART HEALTH QUESTIONS ABOUT YOU | | Yes | No | HEART HEALTH QUESTIONS ABOUT YOUR FAMILY | | Yes | No |
| 4 | Have you ever passed out or nearly passed out during or after exercise? | | | 11 | Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash) | | |
| 5 | Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | | 12 | Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? | | |
| 6 | Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | | | 13 | Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | | |
| 7 | Has a doctor ever told you that you have any heart problems? | | | | | | |

This form is not considered valid unless all sections are complete.



PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

*This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.*

EL2

Revised 4/23

Student's Full Name: _____ Date of Birth: ___ / ___ / ___ School: _____

| BONE AND JOINT QUESTIONS | | Yes | No | MEDICAL QUESTIONS (continued) | | Yes | No |
|--------------------------|---|-----|----|---|--|-----|----|
| 14 | Have you ever had a stress fracture? | | | 26 | Do you worry about your weight? | | |
| 15 | Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | | | 27 | Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 16 | Do you have a bone, muscle, ligament, or joint injury that currently bothers you? | | | 28 | Are you on a special diet or do you avoid certain types of foods or food groups? | | |
| MEDICAL QUESTIONS | | Yes | No | 29 | Have you ever had an eating disorder? | | |
| 17 | Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma? | | | Explain "Yes" answers here: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ | | | |
| 18 | Are you missing a kidney, an eye, a testicle, your spleen, or any other organ? | | | | | | |
| 19 | Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | | | | | | |
| 20 | Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)? | | | | | | |
| 21 | Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | | | | | | |
| 22 | Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? | | | | | | |
| 23 | Have you ever become ill while exercising in the heat? | | | | | | |
| 24 | Do you or does someone in your family have sickle cell trait or disease? | | | | | | |
| 25 | Have you ever had or do you have any problems with your eyes or vision? | | | | | | |

This form is not considered valid unless all sections are complete.

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. Florida Statute 1006.20 requires a student candidate for an interscholastic athletic team to successfully complete a preparticipation physical evaluation as the first step of injury prevention. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

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 physical evaluation required by Florida Statute 1006.20, 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 (ECG), echocardiogram (ECHO), and/or cardio stress test. The FHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____ (printed) Student-Athlete Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ (printed) Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ (printed) Parent/Guardian Signature: _____ Date: ___ / ___ / ___



PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)
*This medical history form should be retained by the healthcare provider and/or parent.
 This form is valid for 365 calendar days from the date signed below.*

EL2

Revised 4/23

PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ___ / ___ / ___ School: _____

PHYSICIAN REMINDERS:

Consider additional questions on more sensitive issues.

| | |
|--|---|
| • Do you feel stressed out or under a lot of pressure? | • Do you ever feel sad, hopeless, depressed, or anxious? |
| • Do you feel safe at your home or residence? | • During the past 30 days, did you use chewing tobacco, snuff, or dip? |
| • Do you drink alcohol or use any other drugs? | • Have you ever taken anabolic steroids or used any other performance-enhancing supplement? |
| • Have you ever taken any supplements to help you gain or lose weight or improve your performance? | |

Verify completion of FHSAA EL2 Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

EXAMINATION

Height: _____ **Weight:** _____

BP: ___ / ___ (___ / ___) **Pulse:** _____ **Vision:** R 20/ _____ L 20/ _____ **Corrected:** Yes No

| MEDICAL - healthcare professional shall initial each assessment | NORMAL | ABNORMAL FINDINGS |
|---|---------------|--------------------------|
| Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | | |
| Eyes, Ears, Nose, and Throat • Pupils equal • Hearing | | |
| Lymph Nodes | | |
| Heart • Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver) | | |
| Lungs | | |
| Abdomen | | |
| Skin • Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis | | |
| Neurological | | |

| MUSCULOSKELETAL - healthcare professional shall initial each assessment | NORMAL | ABNORMAL FINDINGS |
|--|---------------|--------------------------|
| Neck | | |
| Back | | |
| Shoulder and Arm | | |
| Elbow and Forearm | | |
| Wrist, Hand, and Fingers | | |
| Hip and Thigh | | |
| Knee | | |
| Leg and Ankle | | |
| Foot and Toes | | |
| Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test | | |

This form is not considered valid unless all sections are complete.

*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. The FHSAA Sports Medicine Advisory Committee strongly recommends to a student-athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___ / ___ / _____

Address: _____ Phone: (_____) _____ E-mail: _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

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PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/23

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___/___/___
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ City/State: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____ Relationship to Student: _____
 Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
 Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

- Medically eligible for all sports without restriction
 Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

Medically eligible for only certain sports as listed below:

Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

I hereby certify that I have examined the above-named student-athlete using the FHSAA EL2 Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___/___/___
 Address: _____ Phone: (____) _____
 Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp *(if required by school)*

Medications: *(use additional sheet, if necessary)*

List: _____

Relevant medical history to be reviewed by athletic trainer/team physician: *(explain below, use additional sheet, if necessary)*

- Allergies Asthma Cardiac/Heart Concussion Diabetes Heat Illness Orthopedic Surgical History Sickle Cell Trait Other

Explain: _____

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

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct. 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 (ECG), echocardiogram (ECHO), and/or cardio stress test.

This form is not considered valid unless all sections are complete.



PREPARTICIPATION PHYSICAL EVALUATION (Supplement)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/23

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

MEDICAL ELIGIBILITY FORM - Referred Provider Form

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___ / ___ / ___
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ City/State: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____ Relationship to Student: _____
 Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
 Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

Referred for: _____ Diagnosis: _____

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

- Medically eligible for all sports without restriction as of the date signed below
- Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

Medically eligible for only certain sports as listed below:

Not medically eligible for any sports

Further Recommendations: *(use additional sheet, if necessary)*

Name of Healthcare Professional (print or type): _____ Date of Exam: ___ / ___ / ___

Address: _____ Phone: (____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*