

EUSTIS MIDDLE SCHOOL MUSTANGS



REQUIRED FORMS FOR SPORTS PARTICIPATION

*****ATTACH A COPY OF HEALTH INSURANCE CARD*****

LAKE COUNTY SCHOOLS

SPORTS SCREENING PHYSICAL EXAMINATION

NOTICE TO PARENT/LEGAL GUARDIAN

Lake County Schools recommends that your child have a yearly comprehensive physical examination by your personal physician. The screening sport physical, given by volunteer doctors, are not intended to replace your child's regular health maintenance. It is the responsibility of the parent/guardian to make the choice for medical care regarding your child. It is your clear understanding that participation in athletic activities creates a risk normally associated with such activities and that the risk increases as the sport becomes more vigorous and/or involves bodily contact.

PARENTAL/LEGAL GUARDIAN & CHILD/WARD NOTICE OF RESPONSIBILITY & CONSENT FOR PARTICIPATION

As a parent/legal guardian of a student who will be participating in any Lake County School Board (LCSB) athletic activity, your authorization to permit your child/ward to participate requires you understand and agree to certain rules, responsibilities and regulations.

1. Athletics is a sports activity that will require your child/ward to maintain satisfactory grades and behavior in accordance with the LCSB Code of Conduct and school/team rules. Once a child is approved for sports activities you hereby give consent for participation.
2. You understand if a parent, guardian or student falsifies any signature or information on the sports screening physical examination form, the child/ward will be declared ineligible to participate in any Lake County interscholastic activity for one full calendar year from disclosure date.
3. You understand that your child/ward must have a physical evaluation each year and be certified as being physically fit to participate in interscholastic athletic programs. A physical evaluation shall be valid for a period not to exceed one calendar year from the date of practitioner's signature. The student cannot be allowed to participate in any activity related to interscholastic athletic programs until the fully executed physical evaluation form is on file in the school.
4. You further give permission for appropriate school staff and their designees to render medical treatment or authorize medical treatment by a hospital and/or doctor and agree to hold LCSB and its employees harmless in the administration of such assistance.
5. You understand that if the child/ward consults a medical physician concerning any injury received in a LCSB sponsored athletic practice or interscholastic sports contest, written medical approval must be obtained from a physician prior to the child/ward's further participation in activity. You understand that a written doctor's note on the doctor's stationary or prescription pad must be given to the athletic trainer or athletic director before that student will be allowed to resume activity.
6. You also consent for your child to be transported in connection with participation in athletic activities. You fully understand that this consent is given knowing that your child/ward's participation in approved activities may, from time to time, require travel out of state as well as out of and within Lake County. You realize, and agree, that the travel may be by private or publicly owned vehicles, bus, passenger car, on foot or various other means, as deemed appropriate and approved by the school principal.
7. Athletics require that your child/ward and you commit to timely arrival and departure from the activity in accordance with the directive issued by the school principal or coach designated by the school principal to direct said activities. Your failure to timely pick up your child/ward may result in your child/ward's exclusion from the athletic activity.
8. You do authorize and give permission to the school principal, coaches, and school representatives to release your child at the conclusion of the athletic activity. You do authorize and give permission to your child to individually determine his/her method and means of returning to your home upon conclusion of any daily athletic activity including but not limited to his/her walking, riding with a friend, or any other means of transportation he/she chooses. If you have elected to give your child/ward permission herein, you hereby release the LCSB, its employees, agents, and assigns, from any and all liability or claim that may arise from or after your child/ward leaves the athletic activity.
9. You do grant permission to the school principal, coaches, school representatives the right to photograph and/or videotape your child/ward and further to use name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, and promotional materials without reservation or limitation.
10. You do grant permission to LCSB to release any and all athletic injury information relating to the named athlete to the Sports Medicine Program Injury Registry.
11. In addition to the routine sports screening evaluation required by FHSAA Bylaws, you understand and acknowledge that you are hereby advised that your child/ward should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test provided by your personal physician.
12. You further hereby authorize the use or disclosure of your child's/ward's individually identifiable health information should treatment for illness or injury become necessary. You understand that this authorization is voluntary and that you may revoke it at any time by submitting the revocation in writing to your child/ward's school principal.
13. Hazing is defined as any method that causes, or is likely to cause, bodily danger or physical harm, or serious mental or emotional harm to any student. You understand activities that expose individuals to embarrassment, abuse, ridicule, or humiliation will not be tolerated and are subject to enforcement under the LCSB Code of Conduct, depending upon the seriousness of the violation.
14. You and child/ward have read and discussed the LCSB Code of Conduct and acknowledge that she/he may be disciplined or removed from a team if any of the provisions are violated.

I hereby acknowledge and certify that I have read the sports screening document.
I understand and agree to be bound by its terms.

Signature of Parent/Legal Guardian	Printed Name of Parent/Guardian	Date
Signature of Student	Printed Name of Student	Date

FAMILY / STUDENT HEALTH HISTORY

Student Name _____ DOB _____ Sex _____
Street Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Other Phone(s) _____

Identify the answer for each of the following questions as well as circle any questions you are unable to answer. Explain "yes" answers on the next page.

- | | | |
|-----|----|--|
| YES | NO | Have you had a medical illness or injury since your last medical check or sports physical? |
| YES | NO | Do you have an ongoing chronic illness? |
| YES | NO | Have you ever been hospitalized overnight? |
| YES | NO | Are you currently taking any prescription or nonprescription medications or pills or using an inhaler? |
| YES | NO | Have you taken any supplements or vitamins to help you gain or lose weight to improve performance? |
| YES | NO | Do you have any allergies? (For example pollen, medicine, latex, food, or stinging insects) |
| YES | NO | Have you ever had a rash or hives develop during or after exercise? |
| YES | NO | Have you ever passed out during or after exercise? |
| YES | NO | Have you ever been dizzy during or after exercise? |
| YES | NO | Do you get tired more quickly than your friends do during exercise? |
| YES | NO | Have you had a severe viral infection? (For example: myocarditis or mononucleosis) |
| YES | NO | Do you have any current skin problems? (For example: itching, rashes, acne, warts, fungus, blisters or pressure sores) |
| YES | NO | Have you ever become ill from exercising in the heat? |
| YES | NO | Do you cough, wheeze, or have trouble breathing during or after activity? |
| YES | NO | Do you have asthma? |
| YES | NO | Do you have seasonal allergies that require medical treatment? |
| YES | NO | Have you had any problems with your eyes or vision? |
| YES | NO | Do you wear glasses, contacts, or protective eyewear? |
| YES | NO | Have you ever had a sprain, strain or swelling after injury? |
| YES | NO | Have you broken or fractured any bones or dislocated any joints? |
| YES | NO | Do you want to weigh more or less than you do now? |
| YES | NO | Has your weight fluctuated up or down over the past year? |
| YES | NO | If you are female, do you experience any problems with your period? |
| YES | NO | Do you use any special protective or corrective equipment or medical devices that aren't usually for your sport or position? (knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid) |
| YES | NO | Have you ever been hospitalized? (Include date(s) in explanation) |
| YES | NO | Have you ever had surgery? (Include date(s) in explanation) |
| YES | NO | Have you ever had a seizure? |

PHYSICAL EXAMINATION (to be completed by licensed physician, licensed chiropractic physician, licensed osteopathic physician, licensed physician assistant or certified advanced nurse practitioner).

Student Name (please print)

List all sport(s) in which child/ward will participate.

Height _____ Weight _____ % Body Fat (optional) _____ Resting Pulse _____ Blood Pressure _____

Temperature _____ Hearing - Right P _____ F _____ Left P _____ F _____

Visual Acuity - Right: 20/ _____ Left: 20/ _____ Corrected YES NO Pupils Equal _____ Unequal _____

MEDICAL FINDINGS

NORMAL

ABNORMAL FINDINGS

General Appearance _____

Eyes/Ears/Nose/Throat _____

Lymph Nodes _____

Heart _____

Pulses _____

Lungs _____

Abdomen _____

Genitalia (males only) _____

Skin _____

Musculoskeletal

Neck _____

Back _____

Shoulder, Arm _____

Elbow, Forearm _____

Wrist, Hand _____

Hip, Thigh _____

Knee _____

Leg, Ankle _____

Foot _____

ASSESSMENT OF EXAMINING PHYSICIAN ASSESSMENT

_____ Cleared without limitation

_____ Disability _____ Diagnosis _____

_____ Precautions _____

_____ Disability _____ Diagnosis _____

_____ Not cleared for _____ Reason _____

Recommendations _____

Physician Signature _____ Date _____

Physician office stamp must be on this page.

*****COMPLETE TOP & BOTTOM SECTIONS*****
LAKE COUNTY SCHOOLS EMERGENCY TREATMENT AUTHORIZATION CARD

(Please Print)

Student Legal Name _____ School _____ Grade _____

Student DOB _____ Date of last tetanus shot _____ my child/ward has the following allergies _____

_____ child/ward is allergic to the following medications _____

Please identify any serious injuries or disease your child/ward has had _____

Name alternate contact in case of emergency _____ Telephone Number _____

Primary Care Doctor Name _____ Telephone Number _____

I/We the parent/guardian understand that the medical insurance coverage for our/my child/ward is my/our responsibility; whether it is family insurance or purchased school insurance. I/we relieve and release LCSB from any liability in its failure to carry insurance upon our/my child/ward. I/We are providing information for medical insurance coverage for my/our child/ward. I/We further understand that if I/We falsify any insurance information that my/our child/ward will forfeit athletic eligibility from date of disclosure. The information below is required for participation, if you do not have family insurance you must purchase and identify below that you have football/school insurance for your child/ward.

Name of Insurance Company _____ Insurance Policy Number _____

Name of Insurance Contact _____ Telephone Number _____

I/We further give permission for appropriate school staff and their designees to render medical treatment or authorize medical treatment by a hospital and/or doctor and agree to hold the Lake County School Board and its employees harmless in the administration of such assistance. I/We hereby acknowledge and certify that I/We have read the emergency medical document and I/We understand and agree with its terms. According to Florida Statutes (92.525) "Under penalties of perjury, I/we declare that I/we have read the foregoing and that the facts stated in it are true." I/We agree to be bound by its terms and I/we have reviewed and explained the notice with my/our child/ward.

Signature of Parent/Legal Guardian _____ Print Name of Parent Legal Guardian _____ Date _____

Telephone (H) _____ Telephone (W) _____ Other _____

Street Address _____

City _____ State _____ Zip _____

LAKE COUNTY SCHOOLS EMERGENCY TREATMENT AUTHORIZATION CARD

(Please Print)

Student Legal Name _____ School _____ Grade _____

Student DOB _____ Date of last tetanus shot _____ my child/ward has the following allergies _____

_____ child/ward is allergic to the following medications _____

Please identify any serious injuries or disease your child/ward has had _____

Name alternate contact in case of emergency _____ Telephone Number _____

Primary Care Doctor Name _____ Telephone Number _____

I/We the parent/guardian understand that the medical insurance coverage for our/my child/ward is my/our responsibility; whether it is family insurance or purchased school insurance. I/we relieve and release LCSB from any liability in its failure to carry insurance upon our/my child/ward. I/We are providing information for medical insurance coverage for my/our child/ward. I/We further understand that if I/We falsify any insurance information that my/our child/ward will forfeit athletic eligibility from date of disclosure. The information below is required for participation, if you do not have family insurance you must purchase and identify below that you have football/school insurance for your child/ward.

Name of Insurance Company _____ Insurance Policy Number _____

Name of Insurance Contact _____ Telephone Number _____

I/We further give permission for appropriate school staff and their designees to render medical treatment or authorize medical treatment by a hospital and/or doctor and agree to hold the Lake County School Board and its employees harmless in the administration of such assistance. I/We hereby acknowledge and certify that I/We have read the emergency medical document and I/We understand and agree with its terms. According to Florida Statutes (92.525) "Under penalties of perjury, I/we declare that I/we have read the foregoing and that the facts stated in it are true." I/We agree to be bound by its terms and I/we have reviewed and explained the notice with my/our child/ward.

Signature of Parent/Legal Guardian _____ Print Name of Parent Legal Guardian _____ Date _____

Telephone (H) _____ Telephone (W) _____ Other _____

Street Address _____

City _____ State _____ Zip _____

COMPLETE TOP & BOTTOM SECTIONS

COMPLETE TOP & BOTTOM SECTIONS

**Attach a front and back copy of
your child's insurance card on
this page.**