

# 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?   |

- YES NO Do you have frequent or severe headaches?
- YES NO Have you ever had a head injury or concussion? (Include how many and how long ago)
- YES NO Have you ever been rendered unconscious, or lost your memory?
- YES NO Have you ever had a stinger, burner or pinched nerve?
- YES NO Have you ever had numbness or tingling in your arms, hands, legs or feet?
- YES NO Have you ever had chest pain during or after exercise?
- YES NO Have you ever had racing of your heart or skipped heartbeats?
- YES NO Have you had high blood pressure or high cholesterol?
- YES NO Have you ever been told you had a heart murmur?
- YES NO Have you ever been diagnosed with sickle cell anemia?
- YES NO Have you ever been diagnosed with the sickle cell trait?
- YES NO Has a physician ever denied or restricted your participation in sports for any heart problems?
- YES NO Has any family member or relative died of heart problems or sudden death before age 50?
- YES NO Have you had any injuries to, or experienced pain or swelling in muscles, tendons, bones, or joints?

If YES, check appropriate area and explain below:

\_\_\_head \_\_\_elbow \_\_\_neck \_\_\_ankle \_\_\_thigh \_\_\_back \_\_\_wrist \_\_\_toe \_\_\_hand  
 \_\_\_shin/calf \_\_\_shoulder \_\_\_finger \_\_\_upper arm \_\_\_foot \_\_\_forearm \_\_\_chest \_\_\_hip \_\_\_knee

Record the dates of your most recent immunizations (shots) for Tetanus \_\_\_\_\_ Measles \_\_\_\_\_  
 Hepatitis B \_\_\_\_\_ Chickenpox \_\_\_\_\_

EXPLAIN YES ANSWERS BELOW (If more space is needed; attach page.)

\_\_\_\_\_  
 \_\_\_\_\_

**VERIFICATION OF MEDICAL INSURANCE**

Know that I/we do hereby waive, relinquish, remise, and release the LCSB from any claim or cause of action which may arise as a result of my/our said minor child participating in the athletic program of the public school system of Lake County, insofar as I/we have elected to assume said risk, I/we have insured myself/ourselves against said risk. I/We further relieve and release said LCSB from any liability in its failure to provide insurance upon my/our said child/ward while he/she shall be engaged in the program of said public school system. I/We am providing information for medical insurance coverage for my child/ward. If I/we falsify any insurance information I/we understand that my child/ward will forfeit athletic eligibility from date of disclosure. The information below is required for participation. A copy of your valid insurance card must be attached; if you do not have family insurance you must purchase and sign below that you have football and/or school insurance for your child/ward.

Name of insurance company \_\_\_\_\_ Insurance policy number \_\_\_\_\_

Name of insurance contact \_\_\_\_\_ Insurance company phone number \_\_\_\_\_

\_\_\_\_\_  
 Signature of Parent/Legal Guardian Print Name of Parent/Legal Guardian Date

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.

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\_\_\_\_\_  
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.**



**Lake County Schools**  
**Voluntary Extracurricular Activities**  
**Authorization Form and Liability Waiver and Release**

I, \_\_\_\_\_, the parent/legal guardian of \_\_\_\_\_ (hereafter "child/ward") give permission for my child/ward to participate in voluntary extracurricular activities sponsored by Lake County Schools. The novel coronavirus known as COVID-19 has been declared as a worldwide pandemic, spread by person-to-person contact. Federal, state and local agencies recommend social distancing and other measures to prevent the spread of COVID-19.

Beginning in the Summer of 2020 and continuing into the 2020-2021 school year, certain voluntary extracurricular activities will be available to your child/ward. These activities, hereinafter known as "Activity" will be conducted with safety protocols appropriate under the circumstances at the time. For the safety of all people involved, participants in the Activity will be required to adhere to all safety protocols and are subject to immediate removal from the Activity if they do not comply. Extracurricular activities are voluntary and a privilege, not a right, of public school students.

In an effort to ensure the safety and wellness of our school community, I understand the importance of students being healthy and safe when they participate in the Activity. By signing below I agree that I will:

- Perform daily temperature checks on my child/ward to screen for fever before arrival for the Activity. Fever is defined as a temperature over 100 F. If my child/ward has a fever, I will not permit by child/ward to participate in the Activity until he/she has been without a fever for at least 72 hours without fever reducing medication.
- Make a visual inspection of my child/ward for signs of illness which could include: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, flushed cheeks, rapid or difficulty breathing, fatigue or extreme fussiness. If my child/ward has exhibited any of these signs or symptoms, I will not permit them to participate in the Activity until he/she has been without signs or symptoms for at least 72 hours.
- Confirm that my child/ward has not been in contact with someone who has either tested positive for COVID-19 in the past 14 days or is waiting for test results. If my child/ward has been in contact with such a person, I will not permit them to participate in the Activity until 14 days have elapsed since the time of contact.
- Promptly pick up my child/ward or arrange for pickup if signs or symptoms of illness are present. I understand that children are to remain home until illness-free for at least 72 hours without use of medication.

By signing this document below, I acknowledge and affirm all of the statements above. I also voluntarily assume all risks of injury as well as the potential exposure and/or infection of COVID-19 as a result of the participation in the Activity. I agree that such injury, exposure or infection may result in personal injury, illness, sickness and/or death. I understand that the risk of exposure or infection may result from the actions, omissions, or negligence of myself, my child/ward, LCS staff, volunteers, or agents, other Activity participants, or others not listed, and I acknowledge that all such risks are known to me.

In consideration of being permitted to participate in the Activity and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, it is hereby agreed as follows:

I HEREBY RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE, the School Board of Lake County, Florida, and its insurers, members, employees, representatives, contractors, sponsors, agents, successors and assignors (collectively referred to as "Released Parties") from all liability to my child/ward, me, my personal representatives, assigns, heirs and next of kin for any and all loss or damage, and any claim or demands therefore on account of illness or injury of my child/ward and or myself to the person or property or resulting in death, whether caused by the negligence of the releases collectively, of third parties, or otherwise while my child/ward and/or I are observing, attending or in any way participating in the Activity.

I HEREBY AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS the Released Parties and each of them from any loss, liability, damage, or cost they may incur due to my child/ward's or my presence in or upon the area or in any way observing, attending, or in any way participating in the Activity, whether caused by the negligence of the Released Parties or otherwise.

I EXPRESSLY ACKNOWLEDGE AND AGREE THAT ATTENDING, OBSERVING, AND/OR PARTICIPATING IN THE ACTIVITY COULD BE DANGEROUS AND INVOLVE RISK OR SERIOUS INJURY AND/OR DEATH TO ME AND/OR MY CHILD/WARD AND/OR PROPERTY DAMAGE.

I HEREBY ASSUME FULL RESPONSIBILITY FOR COVID-19 EXPOSURE, ILLNESS AND RISK OF BODILY INJURY, DEATH OF MY CHILD/WARD AND OR ME OR PROPERTY DAMAGE due to the negligence of Released Parties or otherwise while in or upon the area and/or while observing, attending, or in any way participating in the Activity.

I further expressly agree that the foregoing release, waiver, and indemnity agreement is intended to be as broad and inclusive as is permitted by law of the State of Florida and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. Further, I agree that if any of the Released Parties seek to enforce this Release due to any claims made by me or by any third party, I will indemnify them for all costs associated with enforcement of this Release, including, but not limited to attorney's fees.

I acknowledge that I have read this Release carefully, in its entirety and fully understand its terms. I acknowledge I have given up substantial rights by signing this form and have signed it freely and voluntarily, intending to be legally bound.

Parent/Guardian Printed Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_