



PANHANDLE AREA EDUCATIONAL CONSORTIUM
EXTRACURRICULAR PARTICIPATION AND FIELD TRIP
MEDICAL INFORMATION RELEASE AUTHORIZATION

The Federal Health Insurance Portability and Accountability Act , commonly referred to as HIPAA, requires an individual, or the individual’s legal representative (parent of a minor, legal guardian, trustee, power of attorney) to provide permission for the release and exchange of that individual’s health information in certain circumstances. If you sign this form, you are giving the health care providers designated below permission to share the information you indicate below. This form complies with the provisions of 45 C.F.R. § 164.508(c) regarding authorizations for release and exchange of protected health information. This form must be filled out entirely.

Purpose of Authorization: This form is designed to allow designated coaches, sponsors, athletic trainers, and school appointed chaperones to obtain health information necessary to determine a student’s fitness and eligibility to participate in extracurricular/sports activities and/or field trips.

Please complete the following:

I/we the parents or legal guardian of _____, an extracurricular/sports participant of the school or person/student traveling on a field trip, give the authorization as indicated below for the communication between medical providers and activity sponsors relative to the status of participation. Student Date of Birth _____

FROM MEDICAL PROVIDERS INDICATED BELOW:

Circle One Only:

A. All Providers

B. No Providers

C. Limited Providers

1 All providers except: _____

2 No providers but: _____

TO DESIGNATED COACHES, SPONSORS, ATHLETIC TRAINERS OR OTHER SCHOOL APPOINTED CHAPERONES:

Circle One Only:

A. Entire Health Record.

B. No protected health information.

C. Limited protected health information (describe information you do not wish for the provider to disclose, including any relevant time periods).

Enter the date that you want this authorization to expire. (If you do not enter a date, this authorization will expire one year from the date this form is signed.) _____

I understand that the information described above may be redisclosed by the person or group that I give the abovespecified health care providers permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release the providers identified above from all liability arising from the disclosure of my health information pursuant to this agreement.

I understand that I may inspect or request copies of any information disclosed by this authorization. I understand that I may revoke this authorization by notifying the Panhandle Area Education Consortium and the specified health care provider, in writing, knowing that previously disclosed information would not be subject to my revocation request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility for benefits.

I have been provided with a copy of this authorization.

Signature of Parent or Legal Guardian Date

Printed Name of Parent or Legal Guardian Relationship to Student.

If there is a legal document verifying that you are acting in a representative capacity for the student identified above, please attach a copy to this authorization.



PANHANDLE AREA EDUCATIONAL CONSORTIUM

EXTRACURRICULAR PARTICIPATION AND FIELD TRIP MEDICAL INFORMATION RELEASE AUTHORIZATION

INTRODUCTION The privacy of medical records and information is protected and insured by new legislation entitled the Health Insurance Portability and Accountability Act (“HIPAA”). This law was developed to safeguard information about an individual’s medical status from improperly being shared, discussed or released without their knowledge. The law is totally inclusive and does not allow for the beneficial communication about medical conditions or status absent valid authorization.

CONCERN – When an individual, especially a minor, participates in an extracurricular activity/field trip, there is always potential for injury or illness that may limit or prohibit participation. In order to make good decisions about the participation status of an individual, sponsors, coaches, directors, and chaperones need information concerning the individual participant’s health status. Under the HIPAA regulations, that information may only be given by the parent or guardian of the minor participant (under 18) or the nonminor participant (18 or over). Medical providers including doctors, physical therapists, nurses, trainers, etc. may not directly discuss any medical condition of an extracurricular activity participant with the director of the activity without written consent from a parent or guardian or the adult participant.

REQUEST FOR CONSENT – Medical providers respect the right to privacy but also understand the need to communicate with activity directors about the participation status of individuals in their care. To accomplish this, a written consent form must be completed indicating the extent that this communication may occur. Three basic levels of consent are possible. These are **A. TOTAL CONSENT, B. NO CONSENT, C. LIMITED CONSENT**. This form is a request for a parent/guardian or adult participant to choose the level of consent desired. Included in the completion of this request form is the designation of what medical providers from whom medical information can be requested. There should be an understanding that total consent is still communication only **BETWEEN** those individuals who **NEED** to know the medical status of the participant. Since knowledge of certain medical information is necessary to determine the participation status and/ or the limitations of that participation (such as preseason medical screening), failure to release such information to the authorized sponsoring individual may disqualify the student from participating in extracurricular activities



STUDENT MEDICAL RELEASE FORM
PANHANDLE AREA EDUCATIONAL CONSORTIUM

Please fill this form out completely and sign

Student's Name _____ Circle one: Male Female
Date of Birth _____ Grade: _____ School Year: 20____
Parent(s) name(s) _____
Guardian(s) name(s) _____
Address: _____
City: _____ Zip: _____ Home Phone: _____
Work Phone: _____ Emergency Phone: _____ Cell Phone: _____
Email: _____@_____.

I/We hereby give my/our permission for my/our child to attend the all school sponsored EXTRACURRICULAR/FIELD TRIPS and PARTICIPATE IN SPORTS events during the next 12 months, beginning in July 1, 20____ to June 30, 20____. I/We understand that there will be adult supervision at these events. I/We also understand that if there are any disciplinary problems with the above named Student, it will be our responsibility to pick up our child at the site of the event and they will not be eligible for future events without specific approval of the school staff in charge of those events or sports.

AUTHORIZATION FOR TREATMENT

I/We, the undersigned, parent(s)/Guardian(s) of the child named above on this consent form, do hereby authorize the school district, it's staff, our representatives, as agent(s) for the undersigned to consent to a X-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care that is deemed advisable by, and is to be rendered under the general supervision of any physician, physician extender, and surgeon licensed under the provisions of the Medicine Practice Act on the Medical Staff of any Hospital or medical clinic whether such diagnosis or treatment is rendered at the office of said physician or said hospitable.

It is understood that this authorization is given in advance of any specific diagnosis, assessment at time of injury treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment deem advisable; and to include emergency or urgent care as deemed necessary by supervising personnel.

The authorization is given pursuant to the provisions of Section 456.057, Florida Statutes, which allows Parent(s) or Guardian(s) to authorize any adult to consent to medical or dental treatment as stated in the above paragraphs).

This authorization shall remain effective from the date below, unless sooner revoked in writing delivered to said agent(s).

Signed _____ Dated _____

Print Name _____
(Parent or Guardian)



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		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___	26. Have you ever become ill from exercising in the heat?	___	___
2. Do you have an ongoing chronic illness?	___	___	27. Do you cough, wheeze or have trouble breathing during or after activity?	___	___
3. Have you ever been hospitalized overnight?	___	___	28. Do you have asthma?	___	___
4. Have you ever had surgery?	___	___	29. Do you have seasonal allergies that require medical treatment?	___	___
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	___	___	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)?	___	___
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	___	___	31. Have you had any problems with your eyes or vision?	___	___
7. Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)?	___	___	32. Do you wear glasses, contacts or protective eyewear?	___	___
8. Have you ever had a rash or hives develop during or after exercise?	___	___	33. Have you ever had a sprain, strain or swelling after injury?	___	___
9. Have you ever passed out during or after exercise?	___	___	34. Have you broken or fractured any bones or dislocated any joints?	___	___
10. Have you ever been dizzy during or after exercise?	___	___	35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	___	___
11. Have you ever had chest pain during or after exercise?	___	___	<i>If yes, check appropriate blank and explain below:</i>		
12. Do you get tired more quickly than your friends do during exercise?	___	___	___ Head	___ Elbow	___ Hip
13. Have you ever had racing of your heart or skipped heartbeats?	___	___	___ Neck	___ Forearm	___ Thigh
14. Have you had high blood pressure or high cholesterol?	___	___	___ Back	___ Wrist	___ Knee
15. Have you ever been told you have a heart murmur?	___	___	___ Chest	___ Hand	___ Shin/Calf
16. Has any family member or relative died of heart problems or sudden death before age 50?	___	___	___ Shoulder	___ Finger	___ Ankle
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___	___ Upper Arm	___ Foot	
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___	36. Do you want to weigh more or less than you do now?	___	___
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)?	___	___	37. Do you lose weight regularly to meet weight requirements for your sport?	___	___
20. Have you ever had a head injury or concussion?	___	___	38. Do you feel stressed out?	___	___
21. Have you ever been knocked out, become unconscious or lost your memory?	___	___	39. Have you ever been diagnosed with sickle cell anemia?	___	___
22. Have you ever had a seizure?	___	___	40. Have you ever been diagnosed with having the sickle cell trait?	___	___
23. Do you have frequent or severe headaches?	___	___	41. Record the dates of your most recent immunizations (shots):		
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	___	___	Tetanus: _____ Measles: _____		
25. Have you ever had a stinger, burner or pinched nerve?	___	___	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, 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: ____/____/____



Preparticipation Physical Evaluation (Page 2 of 3)

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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: _____



Preparticipation Physical Evaluation (Page 3 of 3)

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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.



Consent and Release from Liability Certificate (Page 1 of 4)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the most recent signature.
This form is non-transferable; a change of schools during the validity period of this form will require this form to be re-submitted.

School: _____ School District (if applicable): _____

Part 1. Student Acknowledgement and Release (to be signed by student at the bottom)

I have read the (condensed) FHSAA Eligibility Rules printed on Page 4 of this "Consent and Release Certificate" and know of no reason why I am not eligible to represent my school in interscholastic athletic competition. If accepted as a representative, I agree to follow the rules of my school and FHSAA and to abide by their decisions. I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury, including the potential for a concussion, and even death, is possible in such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved. Should I be 18 years of age or older, or should I be emancipated from my parent(s)/guardian(s), I hereby release and hold harmless my school, the schools against which it competes, the school district, the contest officials and 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 FHSAA because of any accident or mishap involving my athletic participation. I hereby authorize the use or disclosure of my individually identifiable health information should treatment for illness or injury become necessary. I hereby grant to FHSAA the right to review all records relevant to my athletic eligibility including, but not limited to, my records relating to enrollment and attendance, academic standing, age, discipline, finances, residence and physical fitness. I hereby grant the released parties the right to photograph and/or videotape me and further to use my name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein. I understand that the authorizations and rights granted herein are voluntary and that I may revoke any or all of them at any time by submitting said revocation in writing to my school. By doing so, however, I understand that I will no longer be eligible for participation in interscholastic athletics.

Part 2. Parental/Guardian Consent, Acknowledgement and Release (to be completed and signed by a parent(s)/guardian(s) at the bottom; where divorced or separated, parent/guardian with legal custody must sign.)

A. I hereby give consent for my child/ward to participate in any FHSAA recognized or sanctioned sport **EXCEPT** for the following sport(s):

List sport(s) exceptions here

- B. I understand that participation may necessitate an early dismissal from classes.
- C. I know of, and acknowledge that my child/ward knows of, the risks involved in interscholastic athletic participation, understand that serious injury, and even death, is possible in such participation and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. With full understanding of the risks involved, I release and hold harmless my child's/ward's school, the schools against which it competes, the school district, the contest officials and 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 the FHSAA because of any accident or mishap involving the athletic participation of my child/ward. I authorize emergency medical treatment for my child/ward should the need arise for such treatment while my child/ward is under the supervision of the school. I further hereby authorize the use or disclosure of my child's/ward's individually identifiable health information should treatment for illness or injury become necessary. I consent to the disclosure to the FHSAA, upon its request, of all records relevant to my child/ward's athletic eligibility including, but not limited to, records relating to enrollment and attendance, academic standing, age, discipline, finances, residence and physical fitness. I grant the released parties the right to photograph and/or videotape my child/ward and further to use said child's/ward's name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein.
- D. I am aware of the potential danger of concussions and/or head and neck injuries in interscholastic athletics. I also have knowledge about the risk of continuing to participate once such an injury is sustained without proper medical clearance.

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 MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA USES 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 MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA 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 MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

E. **I agree that in the event we/I pursue litigation seeking injunctive relief or other legal action impacting my child (individually) or my child's team participation in FHSAA state series contests, such action shall be filed in the Alachua County, Florida, Circuit Court.**

F. I understand that the authorizations and rights granted herein are voluntary and that I may revoke any or all of them at any time by submitting said revocation in writing to my school. By doing so, however, I understand that my child/ward will no longer be eligible for participation in interscholastic athletics.

G. Please check the appropriate box(es):

____ My child/ward is covered under our family health insurance plan, which has limits of not less than \$25,000.

Company: _____ Policy Number: _____

____ My child/ward is covered by his/her school's activities medical base insurance plan.

____ I have purchased supplemental football insurance through my child's/ward's school.

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE (Only one parent/guardian signature is required)

Name of Parent/Guardian (printed) _____ Signature of Parent/Guardian _____ Date ____/____/____

Name of Parent/Guardian (printed) _____ Signature of Parent/Guardian _____ Date ____/____/____

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE (student must sign)

Name of Student (printed) _____ Signature of Student _____ Date ____/____/____



Consent and Release from Liability Certificate for Concussions (Page 2 of 4)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the most recent signature.

School: _____ School District (if applicable): _____

Concussion Information

Concussion is a brain injury. Concussions, as well as all other head injuries, are serious. They can be caused by a bump, a twist of the head, sudden deceleration or acceleration, a blow or jolt to the head, or by a blow to another part of the body with force transmitted to the head. You can't see a concussion, and more than 90% of all concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. All concussions are potentially serious and, if not managed properly, may result in complications including brain damage and, in rare cases, even death. Even a "ding" or a bump on the head can be serious. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, your child should be immediately removed from play, evaluated by a medical professional and cleared by a medical doctor.

Signs and Symptoms of a Concussion:

Concussion symptoms may appear immediately after the injury or can take several days to appear. Studies have shown that it takes on average 10-14 days or longer for symptoms to resolve and, in rare cases or if the athlete has sustained multiple concussions, the symptoms can be prolonged. Signs and symptoms of concussion can include: (not all-inclusive)

- Vacant stare or seeing stars
- Lack of awareness of surroundings
- Emotions out of proportion to circumstances (inappropriate crying or anger)
- Headache or persistent headache, nausea, vomiting
- Altered vision
- Sensitivity to light or noise
- Delayed verbal and motor responses
- Disorientation, slurred or incoherent speech
- Dizziness, including light-headedness, vertigo(spinning) or loss of equilibrium (being off balance or swimming sensation)
- Decreased coordination, reaction time
- Confusion and inability to focus attention
- Memory loss
- Sudden change in academic performance or drop in grades
- Irritability, depression, anxiety, sleep disturbances, easy fatigability
- In rare cases, loss of consciousness

DANGERS if your child continues to play with a concussion or returns too soon:

Athletes with signs and symptoms of concussion should be removed from activity (play or practice) immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to sustaining another concussion. Athletes who sustain a second concussion before the symptoms of the first concussion have resolved and the brain has had a chance to heal are at risk for prolonged concussion symptoms, permanent disability and even death (called "Second Impact Syndrome" where the brain swells uncontrollably). There is also evidence that multiple concussions can lead to long-term symptoms, including early dementia.

Steps to take if you suspect your child has suffered a concussion:

Any athlete suspected of suffering a concussion should be removed from the activity immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without written medical clearance from an appropriate health-care professional (AHCP). In Florida, an appropriate health-care professional (AHCP) is defined as either a licensed physician (MD, as per Chapter 458, Florida Statutes), a licensed osteopathic physician (DO, as per Chapter 459, Florida Statutes). Close observation of the athlete should continue for several hours. You should also seek medical care and inform your child's coach if you think that your child may have a concussion. Remember, it's better to miss one game than to have your life changed forever. When in doubt, sit them out.

Return to play or practice:

Following physician evaluation, the *return to activity process* requires the athlete to be completely symptom free, after which time they would complete a step-wise protocol under the supervision of a licensed athletic trainer, coach or medical professional and then, receive written medical clearance of an AHCP.

For current and up-to-date information on concussions, visit <http://www.cdc.gov/concussioninyouthsports/> or <http://www.seeingstarsfoundation.org>

Statement of Student Athlete Responsibility

Parents and students should be aware of preliminary evidence that suggests repeat concussions, and even hits that do not cause a symptomatic concussion, may lead to abnormal brain changes which can only be seen on autopsy (known as Chronic Traumatic Encephalopathy (CTE)). There have been case reports suggesting the development of Parkinson's-like symptoms, Amyotrophic Lateral Sclerosis (ALS), severe traumatic brain injury, depression, and long term memory issues that may be related to concussion history. Further research on this topic is needed before any conclusions can be drawn.

I acknowledge the annual requirement for my child/ward to view "Concussion in Sports-What You Need to Know" at www.nfhslearn.com. I accept responsibility for reporting all injuries and illnesses to my parents, team doctor, athletic trainer, or coaches associated with my sport including any signs and symptoms of CONCUSSION. I have read and understand the above information on concussion. I will inform the supervising coach, athletic trainer or team physician immediately if I experience any of these symptoms or witness a teammate with these symptoms. Furthermore, I have been advised of the dangers of participation for myself and that of my child/ward.

Name of Student-Athlete (printed)

Signature of Student-Athlete

Date

Name of Parent/Guardian (printed)

Signature of Parent/Guardian

Date



Florida High School Athletic Association
Consent and Release from Liability Certificate for
Sudden Cardiac Arrest and Heat-Related Illness (Page 3 of 4)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the most recent signature.

School: _____ School District (if applicable): _____

Sudden Cardiac Arrest Information

Sudden cardiac arrest is a leading cause of sports-related death. This policy provides procedures for educational requirements of all paid coaches and recommends added training. Sudden cardiac arrest is a condition in which the heart suddenly and unexpectedly stops beating. If this happens, blood stops flowing to the brain and other vital organs. SCA can cause death if it's not treated within minutes.

Symptoms of sudden cardiac arrest include, but not limited to: sudden collapse, no pulse, no breathing.

Warning signs associated with sudden cardiac arrest include: fainting during exercise or activity, shortness of breath, racing heart rate, dizziness, chest pains, extreme fatigue.

It is strongly recommended all coaches, whether paid or volunteer, are regularly trained in CPR and the use of an AED. Training is encouraged through agencies that provide hands-on training and offer certificates that include an expiration date.

Automatic external defibrillators (AEDs) are required at all FHSAA State Series games, tournaments and meets. The FHSAA also strongly recommends that they be available at all preseason and regular season events as well along with coaches/individuals trained in CPR.

What to do if your student-athlete collapses:

- 1. Call 911
2. Send for an AED
3. Begin compressions

FHSAA Heat-Related Illnesses Information

People suffer heat-related illness when their bodies cannot properly cool themselves by sweating. Sweating is the body's natural air conditioning, but when a person's body temperature rises rapidly, sweating just isn't enough. Heat-related illnesses can be serious and life threatening. Very high body temperatures may damage the brain or other vital organs, and can cause disability and even death. Heat-related illnesses and deaths are preventable.

Heat Stroke is the most serious heat-related illness. It happens when the body's temperature rises quickly and the body cannot cool down. Heat Stroke can cause permanent disability and death.

Heat Exhaustion is a milder type of heat-related illness. It usually develops after a number of days in high temperature weather and not drinking enough fluids.

Heat Cramps usually affect people who sweat a lot during demanding activity. Sweating reduces the body's salt and moisture and can cause painful cramps, usually in the abdomen, arms, or legs. Heat cramps may also be a symptom of heat exhaustion.

Who's at Risk?

Those at highest risk include the elderly, the very young, people with mental illness and people with chronic diseases. However, even young and healthy individuals can succumb to heat if they participate in demanding physical activities during hot weather. Other conditions that can increase your risk for heat-related illness include obesity, fever, dehydration, poor circulation, sunburn, and prescription drug or alcohol use.

By signing this agreement, the undersigned acknowledges that the information on Sudden Cardiac Arrest and Heat-Related Illness have been read and understood. I acknowledge optional educational opportunities in cardiac arrest at www.nfhslearn.org. Please go to www.fhsaa.org/departments/health for further instructions to view the courses. I have been advised of the dangers of participation for myself and that of my child/ward.

Name of Student-Athlete (printed) _____ Signature of Student-Athlete _____ Date ____/____/____

Name of Parent/Guardian (printed) _____ Signature of Parent/Guardian _____ Date ____/____/____



Consent and Release from Liability Certificate (Page 4 of 4)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the most recent signature.

Attention Student and Parent(s)/Guardian(s)

Your school is a member of the Florida High School Athletic Association (FHSAA) and follows established rules. To be eligible to represent your school in interscholastic athletics, in an FHSAA recognized sport (i.e. bowling, competitive cheerleading, girls flag football, lacrosse, boys volleyball, water polo and girls weightlifting or sanctioned sport (i.e. baseball, basketball, cross country, tackle football, golf, soccer, fast-pitch softball, swimming & diving, tennis, track & field, girls volleyball, boys weightlifting and wrestling), the student:

1. **This form is non-transferable**; a separate form must be completed for each different school at which a student participates.
2. Must be regularly enrolled and in regular attendance at your school. **If the student is a home education student or attends a charter school or Florida Virtual School - Full time Program or a special/alternative school or certain small non-member private schools, the student must declare in writing his/her intention to participate in athletics to the school at which the student is permitted to participate.** Home education students and students attending small non-member private schools must be approved through the use of a separate form prior to any participation. (FHSAA Bylaw 9.2, Policy 16 and Administrative Procedure 1.8)
3. Must attend school within 10 days of the beginning of **each semester** to be eligible during **that semester**. (FHSAA Bylaw 9.2)
4. Must maintain at least a cumulative 2.0 grade point average on a 4.0 unweighted scale prior to the semester in which the student wishes to participate. This GPA must include all courses taken since the student entered high school. A sixth, seventh or eighth grade student must have earned at least a 2.0 grade point average on 4.0 unweighted scale the previous semester. (FHSAA Bylaw 9.4)
5. Must not have graduated from any high school or its equivalent. (FHSAA Bylaw 9.4)
6. Must not have **enrolled in the ninth grade for the first time** more than four school years ago. If the student is a sixth, seventh or eighth grade student, the student must not participate if repeating that grade. (FHSAA Bylaw 9.5)
7. Must have signed permission to participate from the student's parent(s)/legal guardian(s) on a form (EL3) provided the school. (Bylaw 9.8)
8. Must be less than 19 years 9 months old to participate in high school; 16 years 9 months old to participate in junior high school; and 15 years 9 months old to participate in middle school, otherwise the student becomes ineligible to participate at that level. Students entering 9th grade in 2014-15 and thereafter must not turn 19 before September 1st, otherwise the student becomes ineligible to participate. (FHSAA Bylaw 9.6)
9. Must undergo a pre-participation physical evaluation and be certified as being physically fit for participation in interscholastic athletics (form EL2).
10. Must be an amateur. This means the student must not accept money, gift or donation for participating in a sport, or use a name other than his/her own when participating. (FHSAA Bylaw 9.9)
11. Must not participate in an all-star contest in a sport prior to completing his/her high school eligibility in that sport. (FHSAA Policy 26)
12. Must display good sportsmanship and follow the rules of competition **before, during and after** every contest in which the student participates. If not, the student may be suspended from participation for a period of time. (FHSAA Bylaw 7.1)
13. Must not provide false information to his/her school or to the FHSAA to gain eligibility. (FHSAA Bylaw 9.1)
14. Youth exchange, other international and immigrant students must be approved by the FHSAA office prior to any participation. Exceptions may apply. See your school's principal/athletic director. (FHSAA Policy 17)
15. Must refrain from hazing/bullying while a member of an athletic team or while participating in any athletic activities sponsored by or affiliated with a member school.

If the student is declared or ruled ineligible due to one or more of the FHSAA rules and regulations, the student has the right to request that the school file an appeal on behalf of the student. See the principal or athletic director for information regarding this process.

By signing this agreement, the undersigned acknowledges that the information on the Consent and Release from Liability Certificate in regards to the FHSAA's established rules and eligibility have been read and understood.

Name of Student-Athlete (printed)

Signature of Student-Athlete

Date

Name of Parent/Guardian (printed)

Signature of Parent/Guardian

Date