aktivate

Register your student athlete for the

2025-2026 school year at Aktivate.com

Without the completed forms, students will not be eligible to tryout or participate!

If your child plans to participate in any sports this school year forms should be returned by 08/29/2025

Fall- Soccer, Cross-Country and Wrestling

Winter- Basketball and Cheerleading

Spring- Volleyball, Flag Football, Floorball and Track and Field

Forms Required

Preparticipation Physical Evaluation- Medical Eligibility Form (Pg.4)

MSAA Interscholastic Sports Parental Permission and Insurance Statement

aktivate FORMERLY REGISTER MY ATHLETE.COM

Registration for Parents

❑ Go to **https://www.registermyathlete.com/login/**

❑ Click Login

❑ Click Create an Account **(You only need ONE account, even if you have children in more than one high school and/or junior high; Do Not create another account if you have used Register My Athlete in the past)**

❑ Fill in personal account information **(this should be the Parent's personal information)**

❑ You will be using the site as a Parent

❑ Click Submit

After you have an account:

❑Login

❑ Under the Parents header (Blue), Click the button labeled "Click here to start/complete athlete registrations". (the first time you log in you will be asked to agree to terms and conditions)

❑ Click Start/Complete a Registration (upper left hand corner of the page)

❑ Click Start a New Registration - this is where you will enter all of your Athlete's information

❑ Click on the red bars to complete all requirements

❑ Click the orange button on the lower left side of the screen for live chat 

or email support@aktivate.com for assistance

Create a Username and password. You only need to register once. If you may be participating in more than 1 sport, then please add all of them when registering.

All forms must be *100% complete* before trying out or participating in athletics at Seminole Middle. All paperwork must be completed prior to going to practice, tryouts, or off-season workouts.

Aktivate Registration Instructions

- **How to Submit the Required Documents, Courses, & Signatures for Athletic Participation:**
  - Online via **https://www.registermyathlete.com/login/**

1) Log in, or Create an Account if this is your first time using Aktivate.com

2) Complete & upload ALL required documents to your Aktivate.com account.

3) Check your Aktivate.com account for "Cleared" status

4) If not cleared, complete and resubmit the missing/incomplete/incorrect document(s).

- **The following documents will need to be completed and uploaded to your Aktivate.com account:**
  - Broward County Parent Sportsmanship Pledge
  - Broward County Student-Athlete Sportmanship Pledge
  - Parent Arranged Transportation Form
  - U-18 Consent Form
  - FHSAA EL 2 Physical form- ATTACHED. NO OTHER FORM ALLOWED. MUST BE UPLOADED.
  - FHSAA EL 3 CONSENT AND RELEASE FORMS (ELECTRONIC SIGNATURES)
  - Birth Certificate Upload- MUST BE UPLOADED
  - Insurance Card Upload- MUST BE UPLOADED
  - NFHS Concussion for Students Course- CERTIFICATE MUST BE UPLOADED
  - NFHS Bullying, Hazing and Inappropriate Behaviors- CERTIFICATE MUST BE UPLOADED
  - NFHS Heat Illness Course- CERTIFICATE MUST BE UPLOADED
  - FHSAA GA4 Participation Form (For Transfer Students Only)

PLEASE EMAIL WILYAN.JONES@BROWARDSCHOOLS.COM FOR ANY QUESTIONS

Middle School Athletic Association MSAA

The Broward County Middle School Athletic Association (MSAA) of Broward County Public Schools is committed to building leaders through sportsmanship, citizenship, and fair play. MSAA currently oversees 59 public and charter middle schools and 8 different sports. The MSAA sports are Soccer, Cross Country, Golf, Basketball, Track & Field Events, Flag Football, Volleyball, and Floorball.

All student-athletes must maintain a minimum of a 2.0 GPA. Students who fall below this standard are ineligible to play.

ELIGIBILITY

1. Students who turn 15 years of age on or before August 31 of the current school year are ineligible to participate in middle school athletic contests.
2. To be academically eligible a student must have been regularly promoted and must maintain 2.0 grade point average or above on a 4.0 unweighted scale for each marking period. If a student fails more than one subject in a marking period they become ineligible. A student's status with regard to eligibility takes effect on the day report cards are issued (P.29 Broward County Code and Conduct Book). An incoming 6th grader is automatically eligible until the end of the **first nine weeks. If an athletes GPA falls below the required unweighted 2.0, he/she receives more than one "U" in conduct or receives an 'F' in more than one course as indicated on the athlete's report card on the day it is issued, he/ she becomes IMMEDIATELY ineligible.**
3. A student who receives more than one "U" conduct grade is ineligible for the following marking period.
4. In the event of any disciplinary action taken by the courts a student's eligibility will be determined by policy established by the School Board of Broward County, Florida.
5. To be eligible to compete in the MSAA playoffs, a student must have been a **PARTICIPATING MEMBER** of that school's team for at **LEAST ONE HALF OF THAT SCHOOL'S REGULAR SEASON.**

INSURANCE/PERMISSION FORM

- Every athlete is required to have proof of insurance on file in the middle school's athletic department.
- If an athlete does not have personal/family insurance, 24-hour accident/injury insurance can be purchased from a School Board approved vendor through the local middle school. See the school Athletic Director for more information.
- The type of insurance the athlete has must be declared on the Parental Permission and Insurance form, as well as a current copy of the insurance card submitted with the form. The parent or guardian must sign the form.

PHYSICALS

- Each athlete is required to undergo a pre-participation physical evaluation and be certified as being physically fit for participation in interscholastic athletics. ***The physical evaluation IS VALID***

FOR ONE YEAR from the date that is was administered. The athlete and parent or guardian must sign this form. This form is to be kept on file in the high school's Athletic Department.

CHARACTER EDUCATION

The district recognizes that while families have the primary responsibility for teaching character, we know that the best way to influence student behavior is to have good character modeled by respected adults in their environment. The School Board of Broward County has adopted eight (8) characteristics as part of the Broward County Public Schools' Standards of Service Policy (6000.1). Through integrating character education into existing school activities, we will continue to provide quality education in a safe and secure learning environment. For more information on Character Education, please refer to the Student Code of Conduct Book.

The eight characters of education are:

- *Responsibility*
- *Citizenship*
- *Kindness*
- *Respect*
- *Honesty*
- *Self-Control*
- *Tolerance*
- *Cooperation*

Participation in sports and extra-curricular activities helps prepare students to become productive citizens. The eight character traits assist students in learning the importance of teamwork sportsmanship, and self-discipline. Through integrating character education into athletic and extra-curricular activities, we will continue to ensure that all students receive a quality education, within a safe and secure learning environment.

MSAA INTERSCHOLASTIC SPORTS
PARENTAL PERMISSION AND INSURANCE STATEMENT

TO: _____, Principal

_____ School

PART I

I, _____(Parent or Guardian), hereby grant permission

for my son/daughter _____, (Birthdate: Mo._____

Day_____ Year_____), to participate in interscholastic sports during the

_____school year.

(Please circle the sports in which your son/daughter **MAY NOT** participate.)

Soccer, Cross Country, Golf, Basketball, Flag Football, Volleyball, Track

My son/daughter has been examined by a physician and is physically qualified to participate in the sports stated above.

The original physical is attached with doctor's stamp of approval.

I authorize my child to accompany the school team, of which he or she is a member, on any of its local or out of town trips; also: I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for my child as a result of game participation.

We have accident insurance with _____ (Name of Insurance Company) which will cover my son/daughter in the event of an interscholastic sport injury as required by School Board Policy #5304. I will assume responsibility for payment of doctor and hospital bills for treatment of any injury my son/daughter might suffer while participating in athletic activities. If any change occurs in this policy, it is the responsibility of the parent to notify the School Principal or Athletic Director.

A photocopy of the front of the Insurer's policy card is attached.

(Signed)_____
Parent or Guardian

****

NOTE

A COPY OF VALID INSURANCE I.D. CARD MUST BE ATTACHED TO THIS FORM

NOTARIZATION

STATE OF FLORIDA
COUNTY OF _____
Sworn to and subscribed before me

this _____day of _____, 20_____

_____
Notary Public

My Commission Expires: _____

****

PART II

INSTRUCTIONS TO PARENT OR GUARDIAN

1. Complete, sign and have the document notarized.
2. Attach proof of Insurance AND proof of Student Physical WITH Doctor's Stamp.

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 of exam.

EL2
Revised 7/25

MEDICAL HISTORY FORM

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

Student's Full Name: _____ Biological Sex: _____ 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 Questionaire 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 Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.	Yes	No
1	Do you have any concerns that you would like to discuss with your provider?		
2	Has a provider ever denied or restricted your participation in sports for any reason?		
3	Do you have any ongoing medical issues or recent illnesses?		
	HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4	Have you ever passed out or nearly passed out during or after exercise?		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7	Has a doctor ever told you that you have any heart problems?		

	HEART HEALTH QUESTIONS ABOUT YOU *(continued)*	Yes	No
8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10	Have you ever had a seizure?		
	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
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)		
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)?		
13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

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

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 of exam.

EL2
Revised 7/25

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

BONE AND JOINT QUESTIONS		Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		
MEDICAL QUESTIONS		**Yes**	**No**
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
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?		

MEDICAL QUESTIONS *(continued)*		Yes	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that you gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

Explain "Yes" answers here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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: ___/___/___

PHYSICAL EXAMINATION FORM

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

HEALTHCARE PROFESSIONAL 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?	• Have you experienced performance changes, felt fatigued, and/or experienced times of low energy during the past year?

☐ 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 #: _____

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date of exam.

EL2

Revised 7/25

MEDICAL ELIGIBILITY FORM

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

Student's Full Name: _____ Biological Sex: _____ 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: (_____) _____

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.

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction after clearance by medical specialist for: _____

(If this option is checked, additional medical follow-up and clearance prior to sports participation is required. Use EL2 Page 5 for documentation.)

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

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

_____

In accordance with §1006.20(2)(c), F.S., I hereby certify that I am a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, or a practitioner who holds an active equivalent licensure issued by the state in which the medical evaluation is performed, and am in good standing with my regulatory board and that I, or a clinician under my direct supervision, 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 #: _____

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 of exam.

EL2

Revised 7/25

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: _____ Biological Sex: _____ 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)*