Awesome Olsen Middle School Athletics

Student Athletic Contract

In participation in interscholastic athletics is a privilege. Students wishing to take advantage of the opportunities presented to them by Olsen Middle School, students/parents will abide by the following:

1. Students/Parents will comply with the Student Code of Conduct Handbook.
2. Students will abide by all school rules, regulations, and policies.
3. Students will maintain a 2.0 or higher. Turn in weekly progress reports on Fridays to the coach.
4. Students understand that if a grade starts falling in class, the student will not be permitted to practice until the grade goes back up.
5. Students will be on time to school in the morning and class every day. Missing school or being late to school will result in consequences. (Running laps, Pushups, bench at a game)
6. Students will be respectful to one another, their teachers, administration, and staff.
7. Students will use language that is socially acceptable. Profanity, vulgar talk and obscene gestures will not be tolerated.
8. Students will be at practice/games on time. Students will notify his/her coach if they are going to be late or not make practice. Being late or missing practices will result in consequences set fourth by the coach. (Running laps, Pushups, Bench at a game)
9. Parents understand the importance of picking their student up on time from practice and games. If a student is being picked up late on numerous occasions, the student will not be able to participate.

I, _____ have read and understand this athletic contract. I know if any rules are broken; the coach has the right to take appropriate actions including the possibility of probation and/or termination from the team.

_____ _____

Student Signature Date

As the parent of _____ I have read and understand the athletic contract. I agree to the policies and procedures of this contract for my child to participate in.

_____ _____

Parent /Guardian Signature Date

Assumption of Risk, Waiver, Release & Hold Harmless

COVID-19 and Voluntary Extracurricular Activities
Summer 2020 and School Year 2020-21

I desire to participate or allow my child(ren) to participate in one or more voluntary extracurricular activities sponsored by the School Board of Broward County, Florida and Broward County Public Schools (collectively, "BCPS "). The novel coronavirus, known as COVID-19, has been declared as a worldwide pandemic and is believed to be contagious and spread by person-to-person contact. Federal, state, and local agencies recommend social distancing and other measures to prevent the spread of COVI D-19.

BCPS will conduct certain extracurricular activities beginning in the Summer of 2020 and continuing into the 2020-21 school year, herein after the "Activity." 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 a privilege, and not a right, of public-school students.

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(ren) to screen for fever before arrival for the Activity. Fever is defined as a temperature over 100.4 F or 38.0 C. If my child(ren) has a fever, I will not permit my child(ren) to participate in the Activity until he/she has been without a fever for at least 5 days.

- Make a visual inspection of my child(ren) 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 breathing or difficulty breathing (without recent physical activity), fatigue, or extreme fussiness. If my child(ren) has exhibited any of these signs or symptoms, I will not permit my child(ren) to participate in the Activity until he/she has been without signs or symptoms for at least 5 days.

- Confirm that my child(ren) 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(ren) has been in contact with such a person, I will not permit my child(ren) to participate in the Activity until 14 days have elapsed since the time of contact.

- Promptly pick up my child(ren) or arrange for pickup if signs or symptoms of illness are present. I understand that my child(ren) are to remain home until illness-free for at least 5 days without the use of medicine.

By signing this document below, I acknowledge and affirm all of the statements above. I also voluntarily assume all risks that I and/or my child(ren) may be exposed to or infected by COVID-19 as a result of participation in the Activity, and that such 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(ren), BCPS 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 my child(ren) being able to participate in the Activity, I, on behalf of myself, as well as anyone entitled to act on my behalf, herby forever waive, release, and hold the School Board of Broward County, Florida, and its employees and agents harmless from any and all claims, suits, liability, actions, judgements, attorney's fees, costs, and any expenses of any kind resulting from injuries or damages, grounded in tort or otherwise, that I and/or my child(ren), or my or our representatives, sustain during or related to my child(ren)'s participation or involvement in the Activity.

By signing this document, you are giving up any right to make a claim or file a lawsuit regarding your child(ren)'s participation in the Activity including any claim based on the negligent acts or omissions of School District employees and agents.

Signature of Parent/Guardian	Signature of Student
Print Name of Parent/Guardian	Print Name of Student
Date of Signature	Date of Signature

MSAA INTERSCHOLASTIC SPORTS
PARENTAL PERMISSION AND INSURANCE STATEMENT

TO: Ms. Valerie Harris, Principal

'Olsen Middle 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

2020-2021 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

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NOTARIZATION

NOTE

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

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

this _____day of _____, 20_____

_____
Notary Public

My Commission Expires: _____

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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.

Awesome Olsen Middle School

Weekly Progress Sheet

Student:_____ Date:_____

Please comment on student's academic performance, behavior, effort, attendance and any other concerns you may have any this time. (i.e., missing assignments, poor tests/project grades, etc.)

SUBJECTS/TEACHER	S = Satisfactory N = Needs Improvement U = Unsatisfactory
LANGUAGE ARTS	*(circle one)* Academics: A B C D F Behavior: S N U Effort: S N U Attendance: S N U
Teacher Signature:	COMMENTS:
READING	*(circle one)* Academics: A B C D F Behavior: S N U Effort: S N U Attendance: S N U
Teacher Signature:	COMMENTS:
MATHEMATICS	*(circle one)* Academics: A B C D F Behavior: S N U Effort: S N U Attendance: S N U
Teacher Signature:	COMMENTS:
SOCIAL STUDIES	*(circle one)* Academics: A B C D F Behavior: S N U Effort: S N U Attendance: S N U
Teacher Signature:	COMMENTS:
SCIENCE	*(circle one)* Academics: A B C D F Behavior: S N U Effort: S N U Attendance: S N U
Teacher Signature:	COMMENTS:
ELECTIVE	*(circle one)* Academics: A B C D F Behavior: S N U Effort: S N U Attendance: S N U
Teacher Signature:	COMMENTS:

Florida HEALTH

STATE OF FLORIDA
School Entry Health Exam

To Parent/Guardian: Please complete and sign Part I — Child's Medical History.
State law for school entry requires a health examination by a legally qualified professional. Additional requirements may be determined by local school districts.

(Please Print)

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First, Middle)	

PART I — CHILD'S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1 through 8 below in the column on the left.
(Please explain any "Yes" answers in the space provided below.)

1. Yes ☐ No ☐ Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes ☐ No ☐ Any other specific illness or social/emotional or behavioral problems?
3. Yes ☐ No ☐ Any allergies (food, insects, medication, etc.)?
4. Yes ☐ No ☐ Any prescription medication (daily or occasionally)?
5. Yes ☐ No ☐ Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes ☐ No ☐ Any hospitalization, operation, or major illness (specify problem)?
7. Yes ☐ No ☐ Any significant injury or accident (specify problem)?
8. Yes ☐ No ☐ Would you like to discuss anything about your child's health with a school nurse?

To Parent/Guardian: Please explain any "Yes" answers from above.

_____

_____

_____

_____

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

☒ _____ _____
Signature of Parent/Guardian — Date

Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

To Parent/Guardian: Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child's ability to learn in school. **(These services are recommended but not required.)**

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____ *(check one)* Optometrist ☐ Ophthalmologist ☐	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____ _____ Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____	Please describe any corrective action for any problems detected and any accommodations required.

Name of Child (Last, First, Middle)	Birth Date

PART II — MEDICAL EVALUATION

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date: ____ ____ ____
(Exam must be within one year of enrollment) Month Day Year

Screening Results:

Height: _____ Weight: _____ BMI%: _____ B/P: _____ Hct/Hgb: _____ Lead: _____ Urinalysis: _____

Vision - Without Glasses	Right 20/____	Left 20/____	Passed ☐ Failed ☐ Referred ☐	Hearing – Right	Passed ☐	Failed ☐	Referred ☐
Vision - With Glasses	Right 20/____	Left 20/____		Hearing – Left	Passed ☐	Failed ☐	Referred ☐

Gross dental (teeth and gums)	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Head/scalp/skin	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Eyes/Ears/Nose/Throat	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Chest/Lungs/Heart	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Abdomen	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Postural assessment	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____

TB risk assessment done ☐ ***(Please review Targeted Testing Guidelines listed below.)***

This child has the following problems that may impact the educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

☐ This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

(This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

☐ This child may participate fully in school activities including physical education.

☐ This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

Signature/Title of Health Care Provider	Date	Address (Please print or stamp)
☒	__/__/__	
Name (Please print or stamp)		

Tuberculosis Targeted Testing Guidelines for Health Care Providers

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if child is in one or more categories. The TB test is administered confidentially as part of the health examination. ***Do not record administration of any TB test or related information on this form.***

- Recent immigrant (< 5 years), frequent visitor to TB endemic areas
- Close contact to active TB case
- Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications

Active TB Disease Risk:

- Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.