Dear Parents/Guardians,

All of the following paperwork MUST be COMPLETED and TURNED IN before your child may participate in any sports practice or competition.

- Preparticipation Physical Evaluation (EL2) page 1 & 2 (& 3 if needed)
- Broward Health Authorization for Release of Medical Information
- Broward Health Consent for Treatment
- Consent & Release form Liability Certificate (EL3)
- Consent & Release form Liability Certificate for Concussion & Heat-Related Illness pages 1 & 2 (EL3CH)
- Copy of Personal Health Insurance Card
  *** Or see Coach Stein for School Insurance Form ***

Jason Stein
Athletic Director
Jason.stein@browardschools.com
Preparticipation Physical Evaluation (Page 1 of 3)

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: ___________________________________________________________________________________

Name of Parent/Guardian: ___________________________  E-mail: ___________________________

Person to Contact in Case of Emergency: ___________________________  Home Phone: (_____)

Relationship to Student: ___________________________  Home Phone: (_____)

Personal/Family Physician: ___________________________  Work Phone: (_____)

City/State: ___________________________  Cell Phone: (_____)

Part 2. Medical History (to be completed by student or parent). Explain “yes” answers below. Circle questions you don’t know answers to.

1. Have you had a medical illness or injury since your last check up or sports physical? __________  __________
2. Do you have an ongoing chronic illness? __________
3. Have you ever been hospitalized overnight? __________
4. Have you ever had surgery? __________
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? __________
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? __________
7. Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)? __________
8. Have you ever had a rash or hives develop during or after exercise? __________
9. Have you ever passed out during or after exercise? __________
10. Have you ever been dizzy during or after exercise? __________
11. Have you ever had chest pain during or after exercise? __________
12. Do you get tired more quickly than your friends do during exercise? __________
13. Have you ever had racing of your heart or skipped heartbeats? __________
14. Have you had high blood pressure or high cholesterol? __________
15. Have you ever been told you have a heart murmur? __________
16. Has any family member or relative died of heart problems or sudden death before age 50? __________
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? __________
18. Has a physician ever denied or restricted your participation in sports for any heart problems? __________
19. Do you have any current skin problems (for example, itching, rashes, acne, wounds, fungus, blisters or pressure sores)? __________
20. Have you ever had a head injury or concussion? __________
21. Have you ever been knocked out, become unconscious or lost your memory? __________
22. Have you ever had a seizure? __________
23. Do you have frequent or severe headaches? __________
24. Have you ever had numbness or tingling in your arms, hands, legs or feet? __________
25. Have you ever had a stinger, burnard or pinched nerve? __________

Part 3. Medical History (to be completed by student or parent). Explain “yes” answers below. Circle questions you don’t know answers to.

26. Have you ever become ill from exercising in the heat? __________  __________
27. Do you cough, wheeze or have trouble breathing during or after activity? __________  __________
28. Do you have asthma? __________
29. Do you have seasonal allergies that require medical treatment? __________
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)? __________
31. Have you had any problems with your eyes or vision? __________
32. Do you wear glasses, contacts or protective eyewear? __________
33. Have you ever had a sprain, strain or swelling after injury? __________
34. Have you broken or fractured any bones or dislocated any joints? __________
35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? __________

If yes, check appropriate blank and explain below:

__________ Head  __________ Elbow  __________ Hip
__________ Neck  __________ Forearm  __________ Thigh
__________ Back  __________ Wrist  __________ Knee
__________ Chest  __________ Hand  __________ Shin/Calf
__________ Shoulder  __________ Finger  __________ Ankle
__________ Upper Arm  __________ Foot

36. Do you want to weigh more or less than you do now? __________
37. Do you lose weight regularly to meet weight requirements for your sport? __________
38. Do you feel stressed out? __________
39. Have you ever been diagnosed with sickle cell anemia? __________
40. Have you ever been diagnosed with having the sickle cell trait? __________
41. Record the dates of your most recent immunizations (shots) for:

   Tetanus: ___________________________  Measles: ___________________________
   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? ___________________________

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 FHSAABuplicate 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: _____/_____/_____
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**

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<td>18. Foot</td>
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* – 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: ________________________________
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: __________________________________________________________________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I ______________________ (Parent/Guardian) hereby authorize physicians, nurses, athletic trainers, or any other healthcare provider (collectively “providers”) of Broward Health (“BH”) to release the health information of ______________________ (Minor’s name) to the School Board of Broward County or its employees, school officials, coaches, teachers or agents, for the purpose of engaging in school athletics and determining child’s ability to participate in school athletics. The health information consists of history, physical, examinations, medical screenings, past or present health information, or information pertaining to injury or illness that may have a bearing on child’s ability to participate in school athletics. I understand BH will release only the minimum amount of information necessary to fulfill a request. I also understand that the health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or BH.

I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign and BH will not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. I understand that I may revoke this authorization at any time by notifying in writing the BH representative at child’s school. In the event I revoke this authorization, it will not have any effect on actions taken by BH prior to the revocation. This authorization expires one year from the date it is signed.

_________________________________________  _______________________
Signature of Parent(s)/Guardian          Date Signed          Relationship to Minor
CONSENT FOR TREATMENT

Minor’s Name: __________________________ Date of Birth: __________

I hereby authorize physicians, nurses, athletic trainers, or any other healthcare provider (collectively “providers”) of Broward Health (“BH”) to conduct routine medical, medical screening, diagnostic, or any other procedure deemed necessary in order for the above minor child (“child”) to participate in school athletics. In the event that an injury occurs to child while participating in school athletics, I further authorize and give permission to providers to render to my child appropriate and necessary care at that time. This may include but not be limited to the rendering of first-aid or emergency treatment. If medical necessity exists beyond that which can be reasonably dealt with on school grounds I further authorize and give permission to providers to arrange for professional medical transport to a medical facility. I understand that every effort will be made to contact the parent or guardian in the case of a medical emergency.

I understand that BH is a teaching facility and that medical, nursing, and other health care personnel in training may participate in child’s care and that these individuals are not necessarily employees or agents of BH. I also understand that BH contracts with physicians and physician groups to provide services to patients, and that they may be independent contractors and are not necessarily the agents or employees of BH. I understand that BH is not legally responsible for the acts and omissions of its independent contractors or these individuals that are not employees or agents of BH. I acknowledge that no guarantees have been made to me regarding the results of any examination, care or treatment to be provided by any BH agent.

Signature of Parent(s)/Guardian          Date Signed          Relationship to Minor

Name of Parent(s)/Guardian

Pre-existing medical condition:

Medication:
Florida High School Athletic Association

Consent and Release from Liability Certificate (Page 1 of 2)

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.

Part 1. Student Acknowledgement and Release (to be signed by student at the bottom)
I have read the (condensed) FHSAA Eligibility Rules printed on the reverse side 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 those 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 the school(s) 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 the mischap 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 the school(s) 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/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/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 USE 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 ANY INJURY SUFFERED DURING 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/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.

- 1 -
Concussion Information

What is a concussion?

A 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.

What are the signs and symptoms of 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

What can happen if my child keeps on playing 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.

What do I do if I suspect my 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.

When can my child 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

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 Parent/Guardian (printed)  ____________________________  Signature of Parent/Guardian  ____________________________  Date  __________/________/___________

Name of Student-Athlete (printed)  ____________________________  Signature of Student-Athlete  ____________________________  Date  __________/________/___________
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 page 1 and page 2 have been read and understood.