Athletic Eligibility for Middle School Students

Parents, in order for your son or daughter to be eligible to participate in athletics at his/her middle school during the upcoming school year, you and your son or daughter must complete this form and sign where indicated. **Make sure you read each page carefully before signing!** A parent or the student (if an adult or emancipated) needs to sign in front of a notary. We **cannot** notarize any papers if they come to us already signed.

ATHLETIC ELIGIBILITY REQUIREMENTS FOR MIDDLE SCHOOL STUDENTS

TRANSFER STUDENTS AND NEW STUDENTS must have transcripts* on file before an athlete is eligible to participate.

ALL STUDENT OBLIGATIONS must be met before participation in athletics/activities is allowed.

ALL SECTIONS OF THIS FORM must be filled out, signed and **MUST BE ON FILE** in Athletic Director's Office ten days prior to the first contest.

ALL STUDENTS MUST HAVE a Birth Certificate* on file in the Athletic Office.

A STUDENT WHO HAS ATTAINED THE AGE OF 15 prior to September 1st of the current school year may submit a hardship waiver to the school's Athletic Director to be considered for participation.

ALL STUDENTS MUST SHOW proof of insurance coverage or purchase student accident insurance which will provide minimal medical reimbursement. The School District is NOT responsible for accidental interscholastic athletic injuries.

A STUDENT MAY participate for three consecutive years from the time he/she first successfully completes the fifth grade.

FAILURE IN MORE THAN ONE (1) SUBJECT during a given 9 week grading period shall cause a student to be ineligible for practice and competition the following 9 week grading period. An "I" incomplete will be considered the same as an "F" until it is replaced with a valid grade. In addition, a student must maintain a specified grade point average of 2.0 as well as acceptable conduct for the previous 9 week period to be eligible. Grades earned in summer school will be calculated to determine the courses passed during the previous term. Grades for courses taken in summer school will be calculated with grades for the last marking period of the previous year to determine eligibility. Student must maintain satisfactory conduct. (S.B. Policy 5.60)

* If specific documentation requested is not available, contact the athletic director for further instruction.

<table>
<thead>
<tr>
<th>Student Name (first, mi, last)</th>
<th>Student ID#</th>
<th>School Year</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date</td>
<td>Age</td>
<td>Gender</td>
<td>Current Grade</td>
</tr>
<tr>
<td>Student Address (street, apt. #, city, state, zip code)</td>
<td>Student Phone #</td>
<td></td>
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<tr>
<td>First School Attended This Year</td>
<td>School(s) Attended Last Year</td>
<td></td>
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<tr>
<td>Name of Emergency Contact</td>
<td>Relationship to Student</td>
<td></td>
<td></td>
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<tr>
<td>Emergency Contact Address (street, apt. #, city, state, zip code)</td>
<td>Emergency Home Phone #</td>
<td></td>
<td></td>
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<tr>
<td>Emergency Work #</td>
<td>Name of Student's Physician</td>
<td>Physician Phone #</td>
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<tr>
<td>List Sports</td>
<td></td>
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</tr>
</tbody>
</table>

PROOF OF INSURANCE FOR STUDENT

| Name of Medical Insurance Company (policy that covers student) | Insurance Policy # |
| Name of Policy Holder (policy that covers student) | Policy Holder's Relationship to Student | Policy Holder's Place of Employment |

School | Athletic Director | Telephone #
INTERSCHOLASTIC ELIGIBILITY RESIDENCE AFFIDAVIT

I live with (check one)  □ Both Parents  □ Mother Only  □ Father Only  □ Guardian  □ Other  ______________________

Relationship to other  ______________________  I have lived with the person(s) stated above since  __________

If the options presented below do not adequately describe your residence situation, attach a note of explanation.

☐ I live in the assigned attendance area for this school.  ☐ I have been accepted into a Choice Program.

☐ I am attending this school on an approved student reassignment (reassignment requires approval by the Reassignment Specialist).

☐ I have been assigned to this school by the Department of Exceptional Student Education.

CONSENT AND RELEASE OF LIABILITY CERTIFICATE - READ CAREFULLY BEFORE SIGNING

I (the student) and we (the parent[s]/legal guardian[s]) have read the (condensed) Florida High School Activities Association (FHSAA) Eligibility Rules and understand that they are a synopsis of the FHSAA By Laws. I/we also understand that a complete copy of the FHSAA By Laws is available to me/us to review at my (the student's) school's administrative office. We know of no reason why I (the student) am not eligible to represent my school in athletic competition. If accepted as a representative, we agree to follow the rules of my school and the FHSAA and to abide by their decisions. I/we know that participation is a privilege. I/we have been informed and know of the risks involved in athletic participation, understand that serious injury, and even death, is possible in such participation and choose to accept such risks. I (the student) voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved. I/we hold harmless and release the student's school, the school district's employees and agents, the schools against which it competes, the Palm Beach County School Board and the contest officials, the National Federation of State High School Associations, (NFHS) and the 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 any of the above-referenced entities because of any accident or mishap involving the student's athletic participation. I/we further authorize EMERGENCY MEDICAL TREATMENT for myself/our child/ward should the need arise for such treatment while I am/my child/ward is under the supervision of the school. In consideration for being allowed to participate in Interscholastic Athletic programs, I/we, for my/our heirs, executors and administrators, release and forever discharge THE SCHOOL BOARD OF PALM BEACH COUNTY, FLORIDA, its agents, representatives and employees of all liability, claims, actions, damages, costs or expenses which I/we may have against them arising out of or in any way connected with my (the student's) participation in an Interscholastic Athletic program, including travel associated with the Athletic Program. I/we understand that this waiver includes any claims based on negligence, action or inaction of any of the above named entities and persons. I/we hereby give permission for the school or District to use the student photograph, video image, writing, voice recording, name, grade level, school name, description of participation and statistics in officially recognized activities and sports, weight and height as a member of an athletic team, dates of attendance, diplomas and awards received, date and place of birth and most recent previous school attended, in newspapers, school productions, web sites, etc. and/or similar school or District-sponsored publications or in school or District-approved news media interviews, videos, articles and photographs. The released parties, however, are under no obligation to exercise said rights herein. I/we hereby give consent for my/our child/ward to participate in the following interscholastic sports that I/we have NOT MARKED OUT. Sports: Baseball, Basketball, Soccer, Fast-Pitch Softball, Track & Field, Volleyball.

I/we understand that participation may necessitate an early dismissal from classes. I/We consent to the disclosure, by my/our child's/ward's school, to the FHSAA, upon its request, of all detailed (athletic or otherwise) financial, scholastic and attendance records of such school concerning my/our child/ward.

Other sports added to form by school:
NOTICE TO THE MINOR CHILD’S NATURAL GUARDIAN

READ THIS FORM COMPLETELY AND CAREFULLY. YOU ARE AGREING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREING THAT EVEN IF THE SCHOOL BOARD OF PALM BEACH COUNTY, FLORIDA 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 THE SCHOOL BOARD OF PALM BEACH COUNTY, FLORIDA, 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 A RIGHT TO REFUSE TO SIGN THIS FORM, AND THE SCHOOL BOARD OF PALM BEACH COUNTY, FLORIDA HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

I/WE HAVE READ THIS CAREFULLY, UNDERSTAND IT, AND KNOW IT CONTAINS A RELEASE
Where appropriate both parent(s)/legal guardian(s) should sign.

_________________________________________  __________________________  
Signature of Student                                      Date                                        

_________________________________________  __________________________  
Signature of Parent/Legal Guardian                            Date                                        

STATE OF FLORIDA
COUNTY OF ________________________________________________

Sworn to or affirmed and subscribed before me this _____ day of _____, _____, by ________________________________________________________.

(  parent/guardian or adult/emancipated student)

Personally Known _______ OR Produced Identification _______  ________________________________  
Type of Identification Produced __________________________________________________________

Signature of Notary Public - State of Florida

COUNTY OF   __________________________________
STATE OF FLORIDA

Personally Known _______ OR Produced Identification _______  ________________________________  
Type of Identification Produced __________________________________________________________

Signature of Notary Public - State of Florida
Student Medical Consent for Athletics

Print Student Name ________________________________  Birth Date ________________

The student, hereby known as patient, and parent(s) or legal guardian(s) whose signatures are attached below do hereby consent to any and all emergency medical and/or surgical treatment including anesthesia and operations which may be advisable by the patient's physicians and/or surgeons. The intention hereof being to grant authority to administer and perform all and singularly examinations, treatments, anesthetics, operations and diagnostic procedures which may be deemed advisable or necessary. We also agree that the patient, when admitted, is to remain in the hospital until his or her physician recommends that the patient is discharged. (Attach any additional pages, if needed, including any relevant provisions in student's IEP or 504 plan.) In the event of an emergency, reasonable attempts will be made to contact the parent. This would not prevent the emergency health care provider from acting in the best interests of the child.

In witness of our consent and agreement to the matters stated in the preceding sentences, we have subscribed our signatures below:

________________________________________  Date

Signature of Student

________________________________________  Date

Signature of Parent/Guardian

________________________________________  Date

Signature of Parent/Guardian

Telephone or cell number to call in case of emergency

________________________________________

NOTARY OF PARENT'S/LEGAL GUARDIAN'S OR ADULT/EMANCIPATED STUDENT'S SIGNATURE

STATE OF FLORIDA

COUNTY OF ________________________________

Sworn to or affirmed and subscribed before me this ________ day of ________, ________.

by _____________________________________________.

________________________________________

(parent/guardian or adult/emancipated student)

________________________________________  Signature of Notary Public - State of Florida

Personally Known __________ OR Produced Identification ______

Type of Identification Produced __________________________________________

PBSD 1589 (Rev. 3/31/2010)  ORIGINAL - School
Florida High School Athletic Association
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)

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Sex:</th>
<th>Age:</th>
<th>Date of Birth: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade in School:</td>
<td>Sport(s):</td>
<td></td>
</tr>
<tr>
<td>Home Address:</td>
<td>Home Phone: ( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Parent/Guardian:</td>
<td>E-mail:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person to Contact in Case of Emergency:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship to Student:</td>
<td>Home Phone: ( )</td>
<td>Work Phone: ( )</td>
<td>Cell Phone: ( )</td>
</tr>
<tr>
<td>Personal/Family Physician:</td>
<td>City/State:</td>
<td>Office Phone: ( )</td>
<td></td>
</tr>
</tbody>
</table>

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? ____ Yes ____ No
2. Do you have an ongoing chronic illness? ____ Yes ____ No
3. Have you ever been hospitalized overnight? ____ Yes ____ No
4. Have you ever had surgery? ____ Yes ____ No
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? ____ Yes ____ No
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? ____ Yes ____ No
7. Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)? ____ Yes ____ No
8. Have you ever had a rash or hives develop during or after exercise? ____ Yes ____ No
9. Have you ever passed out during or after exercise? ____ Yes ____ No
10. Have you ever been dizzy during or after exercise? ____ Yes ____ No
11. Have you ever had chest pain during or after exercise? ____ Yes ____ No
12. Do you get tired more quickly than your friends do during exercise? ____ Yes ____ No
13. Have you ever had racing of your heart or skipped heartbeats? ____ Yes ____ No
14. Have you had high blood pressure or high cholesterol? ____ Yes ____ No
15. Have you ever been told you have a heart murmur? ____ Yes ____ No
16. Has any family member or relative died of heart problems or sudden death before age 50? ____ Yes ____ No
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? ____ Yes ____ No
18. Has a physician ever denied or restricted your participation in sports for any heart problems? ____ Yes ____ No
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)? ____ Yes ____ No
20. Have you ever had a head injury or concussion? ____ Yes ____ No
21. Have you ever been knocked out, become unconscious or lost your memory? ____ Yes ____ No
22. Have you ever had a seizure? ____ Yes ____ No
23. Do you have frequent or severe headaches? ____ Yes ____ No
24. Have you ever had numbness or tingling in your arms, hands, legs or feet? ____ Yes ____ No
25. Have you ever had a stinger, burn or pinched nerve? ____ Yes ____ No

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: / / __
**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).

<table>
<thead>
<tr>
<th>FINDINGS</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
<th>INITIALS*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Appearance</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Eyes/Ears/Nose/Throat</td>
<td></td>
<td></td>
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<tr>
<td>3. Lymph Nodes</td>
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<td>4. Heart</td>
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<tr>
<td>5. Pulses</td>
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<td></td>
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<tr>
<td>6. Lungs</td>
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<tr>
<td>7. Abdomen</td>
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<td></td>
<td></td>
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<tr>
<td>8. Genitalia (males only)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9. Skin</td>
<td></td>
<td></td>
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<tr>
<td><strong>MUSCULOSKELETAL</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10. Neck</td>
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<td></td>
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</tr>
<tr>
<td>11. Back</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Shoulder/Arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Elbow/Forearm</td>
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<td></td>
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</tr>
<tr>
<td>14. Wrist/Hand</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Hip/Thigh</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Knee</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>17. Leg/Ankle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Foot</td>
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</tbody>
</table>

* – 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: ____________________________
Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 3 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.

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: __________________________________________________________________