

PINELLAS COUNTY SCHOOLS
HIGH SCHOOL ACTIVITIES PARTICIPATION FORM
 HOME EDUCATED STUDENTS MUST BE ASSIGNED TO A SCHOOL THROUGH THE DISTRICT AND SHOW PROOF OF IMMUNIZATION

******* NOTICE *******

Participation in competitive athletics, including cheerleading, may result in severe injury, including paralysis, or even death. Improvements in equipment, medical treatment and physical conditioning, as well as rule changes, have reduced these risks, but it is impossible to totally eliminate such occurrences from athletics.

Student Information: _____ / _____ / _____
NAME AS IT APPEARS ON BIRTH CERTIFICATE GENDER GRADE DATE OF BIRTH

Are you an Administrative Transfer (Check One): Yes ___ No ___ **Birth Certificate:** Yes ___ No ___

Parent(s) or Guardian(s) Must Complete This Section

Residence of Parents or Legal Guardian _____ since _____ / _____ / _____
Street Address City Month Day Year

Residence (if Different from Parent(s) or Legal Guardian) _____
Street Address City

Lived at this address since: _____ / _____ / _____
Name(s) and Relationship of Person(s) you live with if other than parent(s) or legal guardian _____
Name Month Day Year

Insurance Students participating in voluntary extracurricular athletics and activities, as defined by Pinellas County School Board Policy 8760, must purchase the Mandatory Student Accident Insurance made available by the School District. Purchase of a student accident insurance policy for football covers football and all other sports and activities requiring mandatory student accident insurance. Purchase of a (non-football) student accident insurance policy covers all (non-football) school related sports and activities requiring mandatory student accident insurance. Insurance may be purchased on-line at <http://www.pcsb.org> site shortcuts PE, Athletics & Extracurricular Activities. Note: This is excess Insurance. It is provided to cover some of the out-of-pocket expenses associated with accidents. It is not intended to replace your primary medical insurance. Any other medical insurance policy will be expected to pay before this excess student accident insurance policy.

Mandatory Football Insurance _____ **Mandatory Student Accident Insurance** _____
Date Purchased Date Purchased

EMERGENCY MEDICAL TREATMENT PERMISSION AND INFORMATION

I hereby authorize the school to obtain, through a physician of its own choice, any emergency care that may become reasonably necessary for the student listed on this form in the course of school sponsored athletics, activities and travel. Payment of all charges incurred for medical treatment is guaranteed by me or the insurance company(s) providing primary and/or excess coverage for the above named student.
*** Please see attached FHSAA Pre-participation Physical Evaluation Form for pertinent medical conditions ***

Student Participation Permission

******* PARTICIPATION IN COMPETITIVE ATHLETICS CAN RESULT IN SERIOUS INJURY, EVEN DEATH *******

I hereby give my consent for the above named student to represent his/her school in school sponsored athletics and activities. I understand the potential risks and that severe injury, including paralysis, or even death may occur. I hereby agree to waive, release and discharge the School and the Pinellas County School Board from any and all liability for any injury or illness of the above named student (s), including death, or for claims of any nature which may result from participating in voluntary school sponsored extracurricular athletics. I agree to indemnify and hold harmless the School and the Pinellas County School Board from claims of any nature including costs, expenses and fees arising out of or as a result of the participant's actions during this activity. This permission includes team travel for local or out-of-town trips. Circle the sport(s) the student intends to play:

Baseball	Bowling	Cheerleading	Flag Football	Golf	Softball	Tennis	Wrestling
Basketball	Cross Country	Football	Soccer	Swimming/Diving	Track	Volleyball	Lacrosse

_____ **School attended last year:** _____

_____ **Student's Signature**

_____ **Signature of Parent/Guardian** _____ **Home/Work Phone** _____ **Date** _____ **Relationship to the Student**

_____ **Signature of Parent/Guardian** _____ **Home/Work Phone** _____ **Date** _____ **Relationship to the Student**

If only one Parent/Guardian signature above, explain reason: _____

The FHSAA web site, www.fhsaa.org, and your school's Athletic Director can best explain student eligibility requirements. If you have any questions about eligibility, please make an appointment with your schools' Athletic Director **before completing this form or trying out**. Participation in extracurricular athletics and activities is a privilege and can be suspended or revoked by the school administration when deemed necessary.

List schools attended by above named student during:
 9th grade: _____
 10th grade: _____
 11th grade: _____
 12th grade: _____

If you have any questions regarding eligibility, meet with your school's Athletic Director **BEFORE** trying out.

Please read both pages and retain a copy of this form before signing and returning to your school or coach



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 signed below.

EL2

Revised 4/23

MEDICAL HISTORY FORM

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

Student's Full Name: _____ Sex Assigned at Birth: _____ 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 Questionnaire 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		Yes	No
Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.			
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		Yes	No
<i>(continued)</i>			
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.



PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

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EL2

Revised 4/23

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

BONE AND JOINT QUESTIONS		Yes	No	MEDICAL QUESTIONS (continued)		Yes	No
14	Have you ever had a stress fracture?			26	Do you worry about your weight?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			27	Are you trying to or has anyone recommended that you gain or lose weight?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?			28	Are you on a special diet or do you avoid certain types of foods or food groups?		
MEDICAL QUESTIONS		Yes	No	29	Have you ever had an eating disorder?		
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?			Explain "Yes" answers here: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____			
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?						

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: ___ / ___ / ___



PREPARTICIPATION PHYSICAL EVALUATION (Page 3 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 signed below.*

EL2

Revised 4/23

PHYSICAL EXAMINATION FORM

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

PHYSICIAN 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?	

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 #: _____

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PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/23

MEDICAL ELIGIBILITY FORM

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

Student's Full Name: _____ Sex Assigned at Birth: _____ 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: (____) _____

- Medically eligible for all sports without restriction
 Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

Medically eligible for only certain sports as listed below:

Not medically eligible for any sports

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

I hereby certify that I 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 #: _____

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.

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 signed below.

EL2

Revised 4/23

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: _____ Sex Assigned at Birth: _____ 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)*