Cocoa High School Athletic Participation Packet

_____, _____ Grade: _____ 2021-2022

Last Name First Name

Address: _____

_____

DOB: _____

Email: _____

Parent Cell # for Emergency Contact: _____

Sports: _____

_____

_____

Type of Form	Form Name	Complete
Parent/Player	EL 2 (Page 1)	
Physical	EL 2 (Page 2,3)	
Liability	EL 3 (Page 1)	
Concussion	EL 3 (Page 2)	
Heat	EL 3 (Page 3)	
Eligibility	EL 3 (Page 4)	
Insurance	Copy	
Health Insurance	Information sheet	
Student signature	All Forms	
Parent Permission	Brevard County	
Birth Certificate	verified (new students)	
Recruitment	GA 4 (Transfer, nontraditional only)	
Code of Conduct	Cocoa High School	
GPA	Verified:	
Cardiac Screening	Verified:	

Packet Completed: ☐ check _____ AD Initials

SCHOOL BOARD OF BREVARD COUNTY, FLORIDA

PARENT PERMISSION AND RESPONSIBILITY STATEMENT FOR OFF-CAMPUS ACTIVITY

School Name _____ Date _____

Student's Name (please print) _____ Grade / Class _____

Activity / Event: _____
List activity (ies) in detail or attach an outline that details all activities occurring during the trip.

On _____ _____
Date(s) of Event Teacher(s)/Sponsor in Charge

TRANSPORTATION BEING PROVIDED (check all that apply)

- Walking - School Bus - Commercial Carrier (bus) - Privately Owned Vehicle

- Leased Vehicle - County Vehicle - None - Other _____ (Describe)

DRIVERS OF PRIVATE OR LEASED VEHICLES (check all that apply)

- Listed Volunteer - Registered Volunteer - Teacher or Staff Member - Other _____ (Describe)

TYPE OF ACTIVITY (Check all that apply)

- Field Trip To _____ (Describe activity) - On Campus Activity

Parents should direct questions concerning the activity to the School Office or the following school personnel:

1. Name _____ Telephone: (___) _____-_____ (___) _____-_____
Teacher – Sponsor in Charge (School Number) (Mobile Phone)

ALL THE ABOVE TO BE COMPLETED BY THE SCHOOL

PARENTAL AUTHORIZATION AND ACKNOWLEDGEMENT OF RISKS

1. I understand that participation in this activity is voluntary, that it is not required, and that it exposes my child to some risk(s).
2. When the school does not provide transportation, the parent or guardian and student are responsible for transportation to and from the off-campus activity.
3. The parent or guardian and student understand that the school district, its officers, agents or employees are not responsible for the student during the time he/she is traveling to or from the off-campus activity, unless the school is providing transportation.
4. The parent or guardian, and student will assume the liability during the entire course of the student's participation in the offcampus activity and will indemnify and hold the School Board of Brevard County harmless for any injury or accident or property loss involving the student.
5. Parent or guardian permission for the student to participate in the above activity (ies) may be withdrawn by written notification to the principal or by a change in the student's schedule approved by the principal or designee.
6. I understand that my child will be involved in activities off school property; therefore, neither the School Board of Brevard County, or its employees and volunteers, will have any responsibility for the condition or use of any nonschool property.
7. In the event of medical emergency, I/We authorize the teacher or chaperone in charge of the Off-Campus activity to seek emergency medical treatment for my child at my expense.

Some field trips may include or have the potential for participation in swimming or other water based activities. Risks and dangers in water may arise from foreseeable or unforeseeable causes. Your signature signifies permission for your child to participate in these activities when supervised by a sponsor(s) and that you will indemnify/hold the School Board of Brevard County harmless for any accident or injury; and hereby assume all risks and dangers and all responsibility for any injury, loss, and/or damage that may occur while your child is engaged in the water related activity (ies).

I/We have read and understand the information above and accept the designated responsibilities. I hereby grant participation in all aspects of this trip - Granted Denied Granted with the following exceptions: _____ (Describe)

_____ _____
Students Signature (Optional for Elementary School) - Date Parent/Guardian Signature (Required for all) – Date

EL2

Revised 03/16

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)

Student's Name: _____ Sex: ____ Age: ____ Date of Birth: ____

School: _____ Grade in School: ____ Sport(s): _____

Home Address: _____ Home Phone: (____) _____

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

Person to Contact in Case of Emergency: _____

Relationship to Student: _____ Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Personal/Family Physician: _____ City/State: _____ Office Phone: (____) _____

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

		Yes	No
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, warts, 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, burner or pinched nerve?	____	____
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? _____

Explain "Yes" answers here: _____

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 ____

EL2

Revised 03/16

Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 2 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 3 of this form to be re-submitted.

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

* – 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: _____

EL2

Revised 03/16

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.

Student's Name: _____

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: _____

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine

EL3

Florida High School Athletic Association

Revised 06/21

Consent and Release from Liability Certificate (Page 1 of 4)

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.

School: _____ School District (if applicable): _____

Part 1. Student Acknowledgement and Release (to be signed by student at the bottom)

I have read the (condensed) FHSAA Eligibility Rules printed on Page 4 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 their 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, stroke 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 my child's schools 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 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 my child's/ward's school, the schools 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. As required by F.S. 1014.05(1), I specifically authorize healthcare services to be provided for my child/ward by a healthcare practitioner, as defined in F.S. 456.001, or someone under the direct supervision of a healthcare practitioner, 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's/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's/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's/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 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 MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA 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 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/I 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.

F. 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 my child/ward will no longer be eligible for participation in interscholastic athletics.

G. Please check the appropriate box(es):

___ My child/ward is covered under our family health insurance plan, which has limits of not less than $25,000.

Company: _____ Policy Number: _____

___ My child/ward is covered by his/her school's activities medical base insurance plan.

___ I have purchased supplemental football insurance through my child's/ward's school.

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE (Only one parent/guardian signature is required)

Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE (student must sign)

Name of Student (printed)	Signature of Student	Date

Florida High School Athletic Association

Revised 06/21

Consent and Release from Liability Certificate for Concussions (Page 3 of 4)

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.

School: ______________________________ School District (if applicable): ______________________

Concussion Information

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, they 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.

Signs and Symptoms of a 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

DANGERS if your child continues to play 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.

Steps to take if you suspect your 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.

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

Parents and students should be aware of preliminary evidence that suggests repeat concussions, and even hits that do not cause a symptomatic concussion, may lead to abnormal brain changes which can only be seen on autopsy (known as Chronic Traumatic Encephalopathy (CTE)). There have been case reports suggesting the development of Parkinson's-like symptoms, Amyotropic Lateral Sclerosis (ALS), severe traumatic brain injury, depression, and long term memory issues that may be related to concussion history. Further research on this topic is needed before any conclusions can be drawn.

I acknowledge the annual requirement for my child/ward to view "Concussion in Sports" at www.nfhslearn.com. 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 Student-Athlete (printed)	Signature of Student-Athlete	Date
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date

Brevard Public Schools

Cardiology Report: Electrocardiogram (ECG)

In accordance with Board Policy 2431 Interscholastic Athletics, as part of the middle and high school athletic packets, The School Board of Brevard County, Florida is requiring each student athlete wishing to participate in middle school and/or high school athletics, to have an electrocardiogram (ECG) screening prior to participating in his/her first athletic sport in middle school. An athlete who had an ECG screening prior to partipating in his/her first athletic sport in middle school would need a second ECG screening prior to participating in his/her first athletic sport in high school, unless a previous ECG screening was completed within the preceding 365 days. An athlete who did not participate in middle school athletics, and therefore had not had a previous ECG screening, would need to have an ECG screening prior to partipating in his/her first athletic sport in high school.

Date: _____ Student's Name: (Print) _____

Name of School: _____

Sex: _____ Date of Birth: _____ Age: _____ Grade: _____ Student ID #: _____

☐ An ECG screening has previously been completed and is on file at _____ School. My child has been cleared for participation in ☐ middle school athletics or ☐ high school athletics.

☐ An ECG Screening was completed and evaluated by an outside vendor. Attached is the documentation clearing my child for participation in ☐ middle school athletics or ☐ high school athletics.

☐ The following represents the findings of the licensed physician or practitioner after reviewing the ECG screening results for my child:

Cardiac Clearance:

(To be completed by a Licensed Physician or Practitioner*)

Low Risk/Cleared for Participation: _____ Higher Risk/Not Cleared for Participation: _____ Date: _____

Name of Licensed Physician or Practitioner*:

_____ _____

(Print Name) (Signature)

Name of Office: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

☐ I decline participation in the ECG screening on behalf of my child although I understand an ECG screening may assist in diagnosing several different heart conditions that may contribute to sudden cardiac death.

_____ _____ _____

Parent/Legal Guardian Name Printed Parent/Legal Guardian Signature Parent/Legal Guardian Phone #

**See Section 1006.20(2)(c), Florida Statutes.*