THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Department of Risk Management
75 N. Pace Blvd., Pensacola, FL 32502

MIDDLE SCHOOL PRE-PARTICIPATION PHYSICAL EVALUATION

School: _____ School Year: 20____-20____

INSTRUCTIONS: 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.

Part 1. Student Information (to be completed by student or parent).

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

Social Security #: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ Home Phone: (_____) _____

Name of Parent/Guardian: _____

Person to Contact in Case of Emergency: _____

Relationship to Student: _____ Home Phone Number: (_____) _____ Work Phone Number: (_____) _____

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 nonprescription (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, to pollen, 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, or blisters)?	___	___
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?	___	___

	Yes	No
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 devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, 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	

	Yes	No
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. Record the dates of your most recent immunizations (shots) for:

Tetanus: _____ Measles: _____

Hepatitus B: _____ Chickenpox: _____

40. Have you ever been diagnosed with sickle cell anemia?	___	___
41. Have you ever been diagnosed with having the sickle cell trait?	___	___

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: _____

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
PRE-PARTICIPATION PHYSICAL EVALUATION **20_____-20_____**

ECHO Needed: ☐ Yes ☐ No

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.

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/Ann			
13. Elbow/Forearm			
14. Wrist/Hand			
15. Hip/Thigh			
16. Knee			
17. Leg/Ankle			
18. Foot			
ECHOCARDIOGRAM (Optional)			

* - station-based examination only Year student-athlete received Echo: _____

ASSESSMENT OF EXAMINING PHYSICIAN

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 or type):_____ Date:_____

Address:_____

Signature of Physician/Physician Assistant/Nurse Practitioner:_____, MD or DO

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 or type):_____ Date:_____

Address:_____

Signature of Physician:_____, MD or DO

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.

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Department of Risk Management
75 N. Pace Blvd., Pensacola, FL 32505

Middle School Athletic Consent and Release from Liability Certificate

School:_____ School Year: 20____-20____

This completed form must be kept on file by the school.

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

If accepted as a representative, I agree to follow the rules of my school 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, 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 school, the schools against which it competes, the contest officials, and The School District of Escambia County 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 School District of Escambia County 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 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.

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE.

Name of Student (printed) _____ Signature of Student _____ Date _____

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), and notarized.)

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. 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's/ward's individually identifiable health information
should treatment for illness or injury become necessary. I consent to the disclosure, by my child's/ward's school, to the FHSAA, upon its request, of all records relevant to his/her athletic eligibility including, but not limited to, his/her 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.

NOTICE TO MINOR CHILD'S NATURAL GUARDIAN

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, AND THE CONTEST OFFICIALS 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, AND THE CONTEST OFFICIALS 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, AND THE CONTEST OFFICIALS HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

E. I/we understand that the authorizations and rights granted herein are voluntary and that I/we may revoke any or all of them at any time by submitting said revocation in writing to my school. By doing so, however, I/we understand that my/our child/ward will no longer be eligible for participation in interscholastic athletics.

F. Please check the appropriate box(es):

____ My/our child/ward is covered under our family health insurance plan, which has limits of not less than $25,000. **(Please attach a photo copy of proof of insurance.)**

Company: _____ Policy Number: _____

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

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 _____

NOTARY

DATE _____ PARENT OR GUARDIAN _____

Signed before me this ____ day of _____ 20____. ____ Identification ____ Known by me

_____
Signature of Notary

Notary Stamp

No student will be allowed to practice or play in any organized sports activity until this document is signed, notarized and returned to the Athletic Department.

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Department of Curriculum and Instruction
75 N. Pace Blvd.
Pensacola, FL 32505

ANNUAL CONSENT TO STUDENT DRUG SCREENING

SCHOOL YEAR _____ _____

I understand that submission to testing for the presence of drugs is a conditions of parking on campus and/or participation in interscholastic athletics and/or extra/co-curricular activities. I further understand if I refuse to take the test, or if the test establishes a violation of the random drug test policy, I will forfeit my privilege of parking on campus and be removed from participation in athletics and/or extra/co-curricular activities until satisfactorily complying with the Random Drug Testing Policy.

By signing and dating this form, I consent to random drug screening and the sanctions thereof throughout the school year. The selection for the random screenings will be performed on a weekly basis with the selected students being notified on the day they are to report for urinalysis.

By signing and dating this form, I understand that the cost of the initial random screening will be paid for by the school district. Furthermore, I understand that the cost of all follow-up drug testing will be the responsibility of the student if the follow-up test results in a positive outcome. If the results are determined to be negative, the district will be responsible for reimbursement. I also understand that the cost for the assessment and rehabilitation program and any additional testing in the event of a violation of the random drug testing policy is also the responsibility of the student.

I hereby consent to the administration of the drug screening and to the conditions listed in this consent. By signing and dating this form, I attest that I have read and understand the attached Random Drug Testing Policy.

Student's Name:_____ Student ID:_____

Date :_____ Signature:_____

Parent/Guardian's Name:_____

Date :_____ Signature:_____

If your child is selected for random drug screening, an attempt will be made to notify you either by phone or letter of both selection for screening and the subsequent result. The best number to reach you is _____. An alternate number is _____.