

**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA**  
**ATHLETIC PARTICIPATION – Preparticipation Physical Evaluation**

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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 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		Yes	No	
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___	26. Have you ever become ill from exercising in the heat?	___	___	
2. Do you have an ongoing chronic illness?	___	___	27. Do you cough, wheeze, or have trouble breathing during or after activity?	___	___	
3. Have you ever been hospitalized overnight?	___	___	28. Do you have asthma?	___	___	
4. Have you ever had surgery?	___	___	29. Do you have seasonal allergies that require medical treatment?	___	___	
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	___	___	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)?	___	___	
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	___	___	31. Have you had any problems with your eyes or vision?	___	___	
7. Do you have any allergies (for example, pollen, latex, medicine, food, or stinging insects)?	___	___	32. Do you wear glasses, contacts, or protective eyewear?	___	___	
8. Have you ever had a rash or hives develop during or after exercise?	___	___	33. Have you ever had a sprain, strain, or swelling after injury?	___	___	
9. Have you ever passed out during or after exercise?	___	___	34. Have you broken or fractured any bones or dislocated any joints?	___	___	
10. Have you ever been dizzy during or after exercise?	___	___	35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	___	___	
11. Have you ever had chest pain during or after exercise?	___	___	<i>If yes, check appropriate blank and explain below.</i>			
12. Do you get tired more quickly than your friends do during exercise?	___	___	___ Head	___ Upper Arm	___ Finger	___ Shin/Calf
13. Have you ever had racing of your heart or skipped heartbeats?	___	___	___ Neck	___ Elbow	___ Foot	___ Ankle
14. Have you had high blood pressure or high cholesterol?	___	___	___ Back	___ Forearm	___ Hip	
15. Have you ever been told you have a heart murmur?	___	___	___ Chest	___ Wrist	___ Thigh	
16. Has any family member or relative died of heart problems or sudden death before age 50?	___	___	___ Shoulder	___ Hand	___ Knee	
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___	36. Do you want to weigh more or less than you do now?	___	___	
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___	37. Do you lose weight regularly to meet weight requirements for your sport?	___	___	
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)?	___	___	38. Do you feel stressed out?	___	___	
20. Have you ever had a head injury or concussion?	___	___	39. Have you ever been diagnosed with sickle cell anemia?	___	___	
21. Have you ever been knocked out, become unconscious, or lost your memory?	___	___	40. Have you ever been diagnosed with having the sickle cell trait?	___	___	
22. Have you ever had a seizure?	___	___	41. Record the dates of your most recent immunizations (shots) for:			
23. Do you have frequent or severe headaches?	___	___	Tetanus: _____	Measles: _____		
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	___	___	Hepatitis B: _____	Chickenpox: _____		
25. Have you ever had a stinger, burner, or pinched nerve?	___	___	<b>FEMALES ONLY (optional)</b>			
			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 OSCEOLA COUNTY, FLORIDA  
ATHLETIC PARTICIPATION – Preparticipation Physical Evaluation**

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**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*
<b>MEDICAL</b>			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitalia (males only)	_____	_____	_____
9. Skin	_____	_____	_____
<b>MUSCULOSKELETAL</b>			
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: \_\_\_\_\_

**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.*



**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA**  
**ATHLETIC PARTICIPATION - Consent and Release From Liability Certificate**

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

**ATTENTION STUDENT AND PARENT(S)/GUARDIAN(S)**

Your school is a member of the Florida High School Athletics Association (FHSAA) and follows established rules. To be eligible to represent your school in interscholastic athletics, in an FHSAA recognized sport (i.e. bowling, competitive cheerleading, girls flag football, lacrosse, boys volleyball, water polo and girls weightlifting) or sanctioned sport (i.e. baseball, basketball, cross country, tackle football, golf, soccer, fast-pitch softball, swimming & diving, tennis, track & field, girls volleyball, boys weightlifting and wrestling), the student:

1. **This form is non-transferable**; a separate form must be completed for each different school at which the student participates.
  2. Must be regularly enrolled and in regular attendance at your school. **If the student is a home education student or attends a charter school or Florida Virtual School - Full Time Program or a special/alternative school or certain small non-member private schools, the student must declare in writing his/her intention to participate in athletics to the school at which the student is permitted to participate.** Home education students and students attending small non-member private schools must be approved through the use of a separate form prior to any participation. (FHSAA Bylaw 9.2, Policy 16 and Administrative Procedure 1.8)
  3. Must attend school within 10 days of the beginning of **each semester** to be eligible during **that semester**. (FHSAA Bylaw 9.2)
  4. Must maintain at least a cumulative 2.0 grade point average on a 4.0 unweighted scale prior to the semester in which the student wishes to participate. This GPA must include all courses taken since the student entered high school. A sixth, seventh or eighth grade student must have earned at least a 2.0 grade point average on a 4.0 unweighted scale the previous semester. (FHSAA Bylaw 9.4)
  5. Must not have graduated from any high school or its equivalent. (FHSAA Bylaw 9.4)
  6. Must not have **enrolled in the ninth grade for the first time** more than four school years ago. If the student is a sixth, seventh or eighth grade student, the student must not participate if repeating that grade. (FHSAA Bylaw 9.5)
  7. Must have signed permission to participate from the student's parent(s)/guardian(s) on a form provided by the school. (FHSAA Bylaw 9.8)
  8. Must not turn 19 before September 1<sup>st</sup>, otherwise the student becomes ineligible to participate. (FHSAA Bylaw 9.6)
  9. Must undergo a pre-participation physical evaluation and be certified as being physically fit for participation in interscholastic athletics. (SDOC Form FC-600-1970)
  10. Must be an amateur. This means the student must not accept money, gift or donation for participating in a sport, or use a name other than his/her own when participating. (FHSAA Bylaw 9.9)
  11. Must not participate in an all-star contest in a sport prior to completing his/her high school eligibility in that sport. (FHSAA Policy 26)
  12. Must display good sportsmanship and follow the rules of competition **before, during and after** every contest in which the student participates. If not, the student may be suspended from participation for a period of time. (FHSAA Bylaw 7.1)
  13. Must not provide false information to his/her school or the FHSAA to gain eligibility. (FHSAA Bylaw 9.1)
  14. Youth exchange, other international and immigrant students must be approved by the FHSAA office prior to any participation. Exceptions may apply. See your school's principal/athletic director. (FHSAA Policy 17)
  15. Must refrain from hazing/bullying while a member of an athletic team or while participating in any athletic activities sponsored by or affiliated with a member school.
- School District of Osceola County, Florida**
16. In the event a fine is imposed by the FHSAA on any school, coach, assistant coach or district employee, student athlete, or school athletic booster club member, no District funds, including internal accounts, shall be used to pay the fine without requiring reimbursement from the responsible person(s).
  17. Students are required to have a cleared ECG screening prior to any participation.
  18. Students transferring schools will need to adhere to the Code of Student Conduct – Athletics, for extracurricular activity.

If the student is declared or ruled ineligible due to one or more of the FHSAA rules and regulations, the student has the right to request that the school file an appeal on behalf of the student. See the principal or athletic director for information regarding this process.

**By signing this agreement, the undersigned acknowledges that the information on the Consent and Release from Liability Certificate in regard to the FHSAA's established rules and eligibility have been read and understood.**

Name of Student-Athlete (Printed)	Signature of Student-Athlete	Date ____/____/____
Name of Parent/Guardian (Printed)	Signature of Parent/Guardian	Date ____/____/____

# THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA

## CONCUSSION, HEAT RELATED ILLNESS AND SUDDEN CARDIAC ARREST - CONSENT AND RELEASE FROM LIABILITY CERTIFICATE

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

### **CONCUSSION:**

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 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.

\* FREE Educational Video on Concussions are located at [www.nfhslearn.com](http://www.nfhslearn.com) and or [sportsafetyinternational.org](http://sportsafetyinternational.org)

### **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 an 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 of 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 athletic 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/headsup/youthsports/> 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, Amyotrophic 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-What You Need to Know" at [www.nfhslearn.com](http://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.

Original: Athletic Director/School  
Copy: Coach

An Equal Opportunity Agency

Page 1 of 2  
FC-600-2561 (Rev. 04/27/20)

**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA**

**CONCUSSION, HEAT RELATED ILLNESS AND SUDDEN CARDIAC ARREST - CONSENT AND RELEASE FROM LIABILITY CERTIFICATE**

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

**SUDDEN CARDIAC ARREST INFORMATION:**

Sudden cardiac arrest is a leading cause of sports-related death. This policy provides procedures for educational requirements of all paid coaches and recommends added training. Sudden cardiac arrest is a condition in which the heart suddenly and unexpectedly stops beating. If this happens, blood stops flowing to the brain and other vital organs. SCA can cause death if it's not treated within minutes.

Symptoms of sudden cardiac arrest include, but not limited to: sudden collapse, no pulse, no breathing.

Warning signs associated with sudden cardiac arrest include: fainting during exercise or activity, shortness of breath, racing heart rate, dizziness, chest pains, extreme fatigue.

It is strongly recommended all coaches, whether paid or volunteer, be regularly trained in cardiopulmonary resuscitation (CPR) and the use of an automated external defibrillator (AED). Training is encouraged through agencies that provide hands-on training and offer certificates that include an expiration date. Beginning June 1, 2021, a school employee or volunteer with current training in CPR and the use of an AED must be present at each athletic event during and outside of the school year, including practices, workouts and conditioning sessions.

The AED must be in a clearly marked and publicized location for each athletic contest, practice, workout or conditioning session, including those conducted outside of the school year.

**What to do if your student-athlete collapses.**

- 1.) Call 911
- 2.) Send for an AED
- 3.) Begin compressions

**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 camps 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, I acknowledge the annual requirement for my child/ward to view both the "Sudden Cardiac Arrest" and "Heat Illness Prevention" courses at [www.nfhslearn.com](http://www.nfhslearn.com) I acknowledge that the information on Sudden Cardiac Arrest and Heat-Related Illness have been read and understood. I have been advised of the dangers of participation for myself and that of my child/ward.**

**I have been advised of the dangers of participation for myself and that of my child/ward. The undersigned, on behalf of themselves, the other parent/guardian, the minor student and all assigns and representatives thereof, and to the fullest extent allowed by Florida Law do hereby knowingly accept the inherent risks presented by participation in this program and as a condition of such participation do hereby release and hold harmless the School Board/District of Osceola County, Florida, and all of its agents and employees from and against any and all lawsuits, claims, actions, damages or any other matter related to or arising out of the student's participation in this program, (the "Released Matters"), including Released Matters that are caused in whole or any part by the negligence of the School Board/District or any employee or agent thereof.**

\_\_\_\_\_  
Name of Student-Athlete (PRINT)

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Name of Parent/Guardian (PRINT)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Original: Athletic Director/School  
Copy: Coach

An Equal Opportunity Agency

THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA  
**Cardiology Report: Electrocardiogram (ECG) Finding**  
**(to be completed by a licensed physician)**

Parents: An ECG screen (also referred to as an EKG) can help identify young athletes who are at risk for sudden cardiac death, a condition where death results from an abrupt loss of heart function. An ECG screening may assist in diagnosing several different heart conditions that may contribute to sudden cardiac death. The School District is requiring one (1) cleared ECG, during a student's four (4) years of high school, to assure the health of any student participating in athletics.

Please have the reviewing physician fill out and sign this form and return to: \_\_\_\_\_ (Name of School)

Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

***ECG in office:***

Normal: \_\_\_\_\_ Abnormal: \_\_\_\_\_

**Cardiac Clearance**

Cleared without limitations: \_\_\_\_\_

Not Cleared: \_\_\_\_\_

Name of Physician or Approved Health Care Professional

Date: \_\_\_\_\_

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature)

Address: \_\_\_\_\_

City / St \_\_\_\_\_ Zip \_\_\_\_\_

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA

2021-22  
SCHOOL YEAR

MEDICAL AUTHORIZATION FORM  
Athletic Department

2021-22  
SCHOOL YEAR

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

I, the undersigned parent/guardian, in the event that I cannot be reached and/or the team is out of the county during an interscholastic event, do hereby authorize the designated SDOC coach or other emergency personnel, if it is deemed necessary, to transport my child to the nearest appropriate healthcare facility and obtain any necessary medical treatment. **This authorization is valid for the 2021-22 school year.**

I further understand that the School Insurance Policy does not guarantee policy benefits. The Student Insurance policy is secondary to all other sources of coverage and may not pay 100% for all incurred medical expenses. Any and all expenses and liability for said expenses incurred as a result of this medical treatment shall be fully assumed by me.

Claim information or eligibility contact: School Insurance of Florida - Policy # 09-0142-2022 (Expires June 30, 2022) P.O. Box 784268, Winter Garden, FL 34778-4628. Phone: 407-798-0290; Fax: 407-798-0296.

In order for you to receive the maximum insurance benefits, for which you are entitled, you MUST use your primary insurance network. Contact your insurance company prior to seeking ongoing treatment for an injury.

Food/ Medication Allergies: \_\_\_\_\_  
\_\_\_\_\_

Special Medical Conditions: \_\_\_\_\_  
\_\_\_\_\_

Insurance Company / Policy Number: \_\_\_\_\_  
\_\_\_\_\_

Date of Last Tetanus Shot (If known): \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Phone Number(s)

\_\_\_\_\_  
Witness (Must be of legal age)

\_\_\_\_\_  
Print Name

**ADDITIONAL EMERGENCY CONTACT INFORMATION**

\_\_\_\_\_  
Print Name / Relationship to Child

\_\_\_\_\_  
Phone Number(s)

\_\_\_\_\_  
Print Name / Relationship to Child

\_\_\_\_\_  
Phone Number(s)



**Assumption of the Risk and Waiver of Liability Relating to  
Coronavirus/COVID-19**

**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 THE SCHOOL DISTRICT OF OSCEOLA COUNTY (“SDOC”) AND NEW DIMENSIONS HIGH SCHOOL 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 SDOC 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 NDHS HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.**

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. **COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

**The School District of Osceola County (“SDOC”) and NDHS** has put in place preventative measures to reduce the spread of COVID-19; however, NDHS **cannot guarantee** that you or your child(ren) will not become infected with COVID-19. Further, **attending NDHS athletic events could increase** your risk and your child(ren)’s risk of exposure to an/or contracting COVID-19.

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By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending SDOC athletic events and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 by attending SDOC athletic events may result from the actions, omissions, or negligence of myself and others, including, but not limited to, SDOC employees, volunteers, and program participants and their families.

**COVID-19 Waiver**

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at or participation in NDHS athletic events ("Claims"). On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, and hold harmless NDHS, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of NDHS, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any SDOC athletic event.

**Signature of Parent/Guardian Date** \_\_\_\_\_

**Print Name of Parent/Guardian** \_\_\_\_\_

**Name of Student Athlete** \_\_\_\_\_