Polk County Public Schools

Consent and Release from Liability Certificate (Middle School)

This completed form must be kept on file by the school. **(PLEASE PRINT)**

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

School: _____ Grade in School: _____

Home Address: _____ Home Phone: _____

Name of Parent/Guardian: _____ Cell Phone: _____

Person to Contact in Case of Emergency: _____ Phone: _____

Student and Parent/Legal Guardian

Student and Parental/Legal Guardian Consent, Acknowledgement and Release (to be completed and signed by student and parent/legal guardian; where divorced or separated, parent/legal guardian with custody must sign).

I am fully aware that practicing, playing, or trying out as a participant in any sport can be a dangerous activity involving **MANY RISKS OR INJURY.** I understand that the dangers and risks of playing, participating, or trying out includes, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and serious injury or impairment to any other aspects of my body, general health and well being. I understand that the dangers and risks of playing, practicing or participating may result not only in serious injury, but in a serious impairment of my future abilities to earn a living, to engage in other business, social, and recreational activities, and generally to enjoy life. I specifically acknowledge that **soccer** is a VIOLENT CONTACT SPORT involving even greater risk of injury than other sports. I expressly acknowledge and agree that the activity is very dangerous and involves the risk of serious injury and/or death and/or property damage.

Because of the dangers of participating in sports, I recognize the importance of following coaches' instructions regarding playing techniques, training and other team rules, etc., and I agree to obey such instructions.

In consideration of the Polk County School District permitting my child to try out for middle school sports and to engage in all activities related to the team, including, but not limited to, trying out, practicing or playing, participating in that sport, **I HEREBY ASSUME ALL THE RISKS ASSOCIATED WITH PARTICIPATING AND AGREE TO HOLD THE POLK COUNTY SCHOOL DISTRICT, ITS EMPLOYEES, AGENTS, REPRESENTATIVES, COACHES, AND VOLUNTEERS HARMLESS FROM ANY AND ALL LIABILITY, ACTIONS, CAUSES OF WHICH MAY ARISE BY OR IN CONNECTION WITH MY PARTICIPATION IN ALL ACTIVITIES RELATED TO SPORTS IN THE MIDDLE SCHOOLS**.

I HEREBY RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE THE POLK COUNTY SCHOOL DISTRICT, ITS EMPLOYEES, AGENTS, REPRESENTATIVES, AND COACHES, (all for the purposes herein referred to as "Releases") from all liability to the undersigned, his/her personal representatives, assigns, heirs, and next of kin for any and all claims, demands, damages, actions, causes of actions, or suits in equity, of whatsoever kind or nature on account of injury to the person or property or resulting in the death of the undersigns, **WHETHER CAUSED BY THE NEGLIGENCE OF THE POLK COUNTY SCHOOL DISTRICT, ITS EMPLOYEES, AGENTS, REPRESENTATIVES, COACHES, AND VOLUNTEERS OR OTHERWISE** which the undersigned is participating, competing and/or practicing for any and all activities related to the team. The terms hereof shall serve as a release and assumption of risks for my heirs, estate, executor, administrators, assignees, and for all members of my family.

We hereby assume full responsibility for the risk of bodily injury, death, or property damage due to the negligence of the Polk County School District, its employees, agents, representatives, coaches, and volunteers or otherwise while participating, competing, trying out, and/or practicing for any and all of the activities related to the team.

We further expressly agree that the foregoing release and waiver is intended to be as broad and inclusive as is permitted by the law of the state in which the event is conducted and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full force and effect.

We have read and voluntarily signed the release and waiver of liability and agreement, and further agree that no oral representation, statement, or inducement apart from the foregoing written agreement has been made.

The undersigned as parent or legal guardian gives consent for the athlete identified herein to engage in extramurals and to accompany the team as a member on its trips.

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 of disclosure of my child's/ward's individually identifiable health information should treatment for illness or injury become necessary.

I understand the Polk County School District has purchased school insurance (secondary coverage) that will cover my child/ward in all approved and supervised athletic activities. I understand that should I have medical insurance; that my policy is primary for all medical expenses and the school insurance will be the secondary policy. I also understand that I will be responsible for any medical expenses not covered by school insurance or my/our insurance.

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

Signature of Student: _____ Signature of Parent/Guardian: _____

Date: _____ Date: _____

Polk County Public Schools

MIDDLE SCHOOL Preparticipation Physical Evaluation (Page 1 of 2)

(Athletic Physicals in Polk County Public Schools are valid from June 1 - May 31)

MUST BE TURNED IN DIRECTLY TO PRINCIPAL

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: _____
Hepatitus 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: ____/ ____/ ____

Polk County Public Schools

MIDDLE SCHOOL Preparticipation Physical Evaluation (Page 2 of 2)

(Athletic Physicals in Polk County Public Schools are valid from June 1 - May 31)

PART 1 & 2 MUST BE COMPLETED/SIGNED BEFORE PHYSICAL EVALUATION. Revised 10/12

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: _____