

# UMATILLA HIGH SCHOOL

# BULLDOG BAND

All band paperwork is due on JULY 24  
(before band camp begins).

- |  |  |
|--|--|
| <input type="checkbox"/> Band Fee Commitment               | <i>with \$75 commitment &amp; camp fee</i> |
| <input type="checkbox"/> Band Contract                     | <i>signed</i>                              |
| <input type="checkbox"/> Uniform Contract                  | <i>signed</i>                              |
| <input type="checkbox"/> Student Info Form                 | <i>with valid email address</i>            |
| <input type="checkbox"/> <b>LCS Waiver &amp; FT Form</b>   | <b>NOTARIZED</b>                           |
| <input type="checkbox"/> Medical/Prescription Release Form | <i>signed by a doctor</i>                  |
| <input type="checkbox"/> Non-Medical Release Form          | <i>optional</i>                            |
| <input type="checkbox"/> Parent Volunteer Form             | <i>with the VECHS Agreement</i>            |
| <input type="checkbox"/> Summer Contact Info               | <i>online</i>                              |
| <input type="checkbox"/> <b>Sports Physical Paperwork</b>  | <b><i>due online by July 1st!</i></b>      |

# 2026 - 2027

*yearly paperwork*

# BAND FEE COMMITMENT

2026 - 2027 Yearly Band Paperwork

**Yearly Band Fees**

**\$275 total**

Cash, checks made payable to UHS Band Boosters, and [online payment](#) is accepted.

- |                               |                       |                |
|-------------------------------|-----------------------|----------------|
| <input type="checkbox"/> \$25 | <b>Commitment Fee</b> | <b>July 31</b> |
| <input type="checkbox"/> \$50 | <b>Band Camp Fee</b>  | <b>July 31</b> |
| <input type="checkbox"/> \$50 | Band Fee Payment #1   | October 9      |
| <input type="checkbox"/> \$50 | Band Fee Payment #2   | December 18    |
| <input type="checkbox"/> \$50 | Band Fee Payment #3   | March 4        |
| <input type="checkbox"/> \$50 | Band Fee Payment #4   | May 28         |



**Total Owed:** \$75.00 \_\_\_\_\_ **Total Paid:** \$ \_\_\_\_\_

**Payment Type:**  Cash  Check # \_\_\_\_\_ (payable to UHS Band Boosters)  Online

## **Band Fee Commitment Contract**

- I understand that my child has financial responsibility to the Umatilla Band Program through yearly band fees and multiple required fundraisers.
- I commit to paying the required band fees by the due dates listed above, and understand that a payment plan will be established for funds that are not paid by these due date.
- I understand that following the final due date, delinquent band accounts will be turned over to the media center's county Destiny Account (at that point only accept cash or cashier's check will be accepted as payment).
- Finally, I understand that any financial hardships that will impact your student's music education should be clearly communicated with the band director. Help cannot be provided unless communicated.

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Grade Level**

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**

# BAND CONTRACT

2026 - 2027 Yearly Band Paperwork

I, \_\_\_\_\_, agree to follow the expectations and policies of the Umatilla High School Bulldog Band to the best of my ability.

*Initials*

*As a UHS Bulldog Band Member, I will...*

Have an attitude of humility, encouragement, and helpfulness, because I understand that the band needs to work together to be successful

Hold myself to the highest standard of behavior in all my classes, during rehearsals, during concerts, and on field trips

Be committed to fundraising for the band during every fundraiser

Be committed to paying my yearly band fees

Be committed to practicing and taking good care of my instrument and the UHS Band property

Understand extreme misconduct or disrespect can lead to loss of privileges and/or removal from the UHS Band Program

Am aware of scheduled band rehearsals, concerts, competitions, and events and understand that these are required and can affect my grade

**BY SIGNING THIS CONTRACT, YOU INDICATE TO THE BAND DIRECTOR AND THE SCHOOL ADMINISTRATION THAT YOU HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OUTLINED IN THIS HANDBOOK, AS WELL AS YOUR COMMITMENT TO BEING IN THE UHS BAND.**

*Student Signature*

*Grade Level*

*Parent Signature*

*Date*

# UNIFORM CONTRACT

2026 - 2027 Yearly Band Paperwork

Student Name: \_\_\_\_\_

I have read the rules concerning the care and maintenance of the Marching Band, Colorguard, Concert, and Jazz uniforms. I understand the rules and agree that any damages to the uniform (in part or total) will be paid for by the student. The following items have been issued for the 2026 - 2027 school year:

UNIFORM ITEM REPLACEMENT	COST
Marching Uniform Coat	\$200
Marching Bibbers	\$45
Shako	\$55
Plume	\$25
Concert Dress	\$70
Concert Pants	\$35
Concert Coat	\$65
Concert Shirt	\$20
Bowtie	\$10
Hanger	\$5
T-shirt	\$15
Brooch	\$10
Color Guard Pants	\$45
Color Guard Top	\$55
Gloves	\$5
Jazz ties	\$10
Practice flag pole	\$15
Practice flag	\$10
Gauntlets	\$15
Button Covers	\$5
Color Guard Uniform	\$80

\_\_\_\_\_  
*Student Signature*

\_\_\_\_\_  
*Grade Level*

\_\_\_\_\_  
*Parent Signature*

\_\_\_\_\_  
*Date*

# UNIFORM CONTRACT

## 2026 - 2027 Yearly Band Paperwork

### Marching Uniform:

- The student's marching band uniform is the property of Umatilla High School. If at any time the uniform becomes damaged or lost, it will be the responsibility of the student to secure replacement garments at their own cost.
- At the beginning of each year, the students will be fitted for shoes (Dinkles). Each student must purchase the required marching shoes and black socks.
- At the beginning of each year each student in Marching Band will be fitted for bibbers. If at any time the bibbers becomes damaged or lost, it will be the responsibility of the student to secure replacement garments at their own cost.
- At the beginning of the year each student in Marching Band will be issued the year's marching show t-shirt. This t-shirt is part of the official Marching Uniform and must be worn under the marching jacket.
- Each student is responsible for keeping their uniform in good condition, clean and stain free.
- Each student must report to the band room prior to each game wearing their bibbers, black socks, marching shoes, and marching show t-shirt.. The uniform must be clean and wrinkle free.
- After performances, the uniform coats, shakos, and plumes must be checked in with the uniform band parent and officers and will be stored in the band room until the next event needed. The coats must be HUNG PROPERLY on their hanger. Shakos and plumes must be stored properly in their cases. No student may leave after an event until their uniform has been properly stored.
- At the end of the marching season (Jan), each student is responsible for cleaning and returning their marching bibbers to the uniform parent. If this is not turned in, then the students' account will be charged for that item at this time.

### Concert Uniform:

- The student's concert band uniforms are owned by Umatilla High School. UHS takes the responsibility for the cleaning, alterations, and minor mending of the uniforms.
- At the beginning of each year, the students will be fitted for concert uniforms and assigned the appropriate garments.
- It is the student's responsibility to take good care of their concert uniform. Any lost or irreparable garments will be replaced by the student.
- The Boys Formal Uniform consists of Black Tuxedo Pants and Black Tuxedo Shirt with Black Banded Collar. Black socks and black shoes are the responsibility of the student.
- The Girls Formal Uniform consists of a black floor length dress. Black shoes are the responsibility of the student.
- The student is expected to be in full uniform as described at all formal performances.
- Uniforms are to be turned in at the end of the semester to the uniform parent. Any missing items at this time will be charged to the students' account.

### Jazz Uniform:

- At the beginning of the semester, the student will be provided with a numbered orange tie. Black pants, black long sleeved shirts, black socks and black shoes are the responsibility of the student.
- It is the student's responsibility to take good care of their jazz tie. Any lost or irreparable garments will be replaced by the student.

### Band T-shirts:

- Marching Band shirts will be distributed at the beginning of the year. These shirts must be kept in good condition and stain free. If at any time one of the band t-shirts is misplaced, lost, or damaged, the student will be responsible for purchasing the replacement prior to the next event it is needed for. The replacement cost is \$15.00 per shirt.

# STUDENT INFO FORM

2026 - 2027 Yearly Band Paperwork

Student Name

Instrument

Grade

Home Address

City, State

Zip

## CONTACT INFORMATION:

Student Cell Phone

Student Email

Parent Name (mom)

Parent Name (dad)

Cell Phone (mom)

Cell Phone (dad)

Email (mom)

Email (dad)

Emergency Contact (other than parent)

Phone Number

Relationship

## RENTAL INFORMATION:

School Instrument Rental Needed (circle one): YES NO *(If no, please fill out below)*

Colorguard/Percussion Equipment Rental Needed: YES NO

Personal Instrument(s):

Instrument

Brand

Serial Number

Instrument

Brand

Serial Number

## ADDITIONAL STUDENT INFORMATION:

Please share any information about your child that will help us better meet his/her needs. This information will be kept confidential. (ex. medical needs, allergies, mental health needs, club/sports involvements, work/jobs, etc.)

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# FIELD TRIP FORM

2026 - 2027 Yearly Band Paperwork

## LAKE COUNTY SCHOOLS FIELD TRIP/SCHOOL ACTIVITY PARENT CONSENT/LIABILITY WAIVER/MEDICAL RELEASE

OVERNIGHT  
 OUT-OF-STATE  
 OFF CAMPUS

Student \_\_\_\_\_ School \_\_\_\_\_  
Club/Group/Class \_\_\_\_\_ Supervising Faculty Member \_\_\_\_\_  
Activity \_\_\_\_\_ Location \_\_\_\_\_  
Date & Time of Departure \_\_\_\_\_ Date & Time of Return \_\_\_\_\_  
Method of Transportation :  School Bus  Charter Bus  Private Car  Leased Vehicle  Walking  Other

### MEDICAL INFORMATION

Does your child have any of the following conditions?

Epilepsy/Seizures  Yes  No      Motion Sickness  Yes  No      Diabetes  Yes  No  
Any Medication  Yes  No      Asthma/Wheezing  Yes  No      Heart Disease  Yes  No  
Muscular/Skeletal Problems  Yes  No      Hemophilia/Bleeding Disorders  Yes  No      Allergies: \_\_\_\_\_

Is there any other condition which might possibly require treatment and/or medication during the trip? Yes  No  If yes, you must complete and attach the Administration of Non-Prescription Medication Consent Form and/or the Administration of Prescription Medication Consent Form.

### PARENT CONSENT / LIABILITY WAIVER / MEDICAL RELEASE

I/We hereby give permission for my child to accompany employees of the LCSB, acting as chaperones, to \_\_\_\_\_ for the days indicated above. I/We will not hold the LCSB nor their agents or employees accompanying the group responsible for any accident or injury to my child/ward.

In the event my child/ward causes any property damage or personal injury, whether individually or in concert with other persons or entities, I/we agree to indemnify and hold harmless the LCSB, its agents and employees.

I/We have read all the information in regards to this trip. I/we are aware of guidelines of said trip and the number of chaperones which will accompany my/our child/ward.

I/We hereby grant permission to the attending physician or his consulting physicians, to render to my/our child/ward any emergency treatment, medical or surgical care that might be deemed necessary to the health and well-being of said child/ward. Also, when necessary for the administering of such care, I/we grant permission for hospitalization at an accredited hospital.

I/We assume full responsibility and liability for any and all expenses, damage, accident, illness, injury or medical expense of and to my/our child/ward or my/our property resulting from such participation. I/We attest and affirm that the participant has no limitation that should prevent participation in the activity and I/we have not been advised or informed by anyone to the contrary.

I/We further agree to inform the appropriate school official(s) should my/our child/ward's physical condition change in any way and any time so as to affect his/her participation in the activity herein named.

I/We further relieve and release said LCSB from any liability in its failure to carry insurance upon my/our said child/ward.

Our/My child/ward has medical insurance  Yes  No

**If yes, you must attach a copy of proof of insurance to this form.**

Insurance Co \_\_\_\_\_

Policy # \_\_\_\_\_

Cell Phone \_\_\_\_\_

Emergency Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Parent/Guardian Name (Please Print) \_\_\_\_\_

Parent/Guardian Name (Signature) \_\_\_\_\_

Date \_\_\_\_\_

THIS SECTION MUST BE COMPLETED BY PARENT/GUARDIAN ONLY IF CHILD/WARD IS GOING OUT-OF-STATE OR OVERNIGHT

(SIGN IN PRESENCE OF A NOTARY)

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

### NOTARY STATEMENT STATE OF FLORIDA, COUNTY OF LAKE

On \_\_\_\_\_ before me personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the instrument and acknowledged to me that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument, the person or the entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal \_\_\_\_\_

One copy must be retained by the administration and a duplicate copy must accompany the sponsor when leaving school property with student

# PRESCRIPTION RELEASE FORM

2026 - 2027 Yearly Band Paperwork

## LAKE COUNTY SCHOOLS

### ADMINISTRATION OF PRESCRIPTION MEDICATION CONSENT FORM

Medications must be brought to school by the parent; NEVER by the student. The medication must be presented to school personnel in the original container with a current date. **Metered inhalers should have the label affixed to the inhaler for easy identification or must be in the original box with prescription label.** The parent must give the first dose of prescription medication at home. Under no circumstances will the school accept more than a four-week (30 days) supply of prescription medication. Parents may request that the pharmacist dispense two labeled bottles for medication, one for home and the other for school.

Student \_\_\_\_\_ DOB \_\_\_\_\_

Parent \_\_\_\_\_ School \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_

Name of medication \_\_\_\_\_

Dosage to be given \_\_\_\_\_ Time to be given \_\_\_\_\_

Diagnosis \_\_\_\_\_ Allergies \_\_\_\_\_

Date to start \_\_\_\_\_ Last date to be given \_\_\_\_\_

Please circle one:      **may**      **may not**      carry and use the inhaler himself/herself.

Special instructions on administration of medication (i.e. to be given after lunch, do not chew, to be given with food, etc.)

Reaction(s) that may occur \_\_\_\_\_

I request Lake County Public School personnel to administer medication as directed by this authorization. If there are questions regarding this medication I authorize the School Nurse/District Nurse to contact ordering physician as needed throughout the school year.

It is the parent's responsibility to pick up medications that are no longer needed at school. Medications that have expired and/or are discontinued during the school year will be disposed of within a week of the expiration or discontinuation date. At the end of the school year left over or unused medications will be disposed of immediately after the last day of school.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

Physician's Official Stamp

# NON-PRESCRIPTION RELEASE FORM

2026 - 2027 Yearly Band Paperwork

## LAKE COUNTY SCHOOLS

### ADMINISTRATION OF NON-PRESCRIPTION MEDICATION CONSENT FORM

Non-prescription medication may be administered at school by school personnel when such medication is necessary for school attendance and cannot otherwise be accomplished. The non-prescription medication may be administered for 72 consecutive hours, once in the school year. Medication must be brought to school by parent/guardian in a sealed, unopened container. A form must be completed for each medication administered.

Student Name \_\_\_\_\_ DOB \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Name of non-prescription medication \_\_\_\_\_

Dose to be given \_\_\_\_\_ Time(s) to be given \_\_\_\_\_

Diagnosis \_\_\_\_\_ Allergies \_\_\_\_\_

Purpose/reason for this medication \_\_\_\_\_

Discontinue date \_\_\_\_\_

Instruction(s) (i.e. take with water, milk, food) \_\_\_\_\_

What reaction(s) may occur, if known? \_\_\_\_\_

I request Lake County Public School personnel administer medication as directed by this authorization.

**A doctor's signature is required if:**

- A medication is necessary beyond the 72 consecutive hours
- When medication needs to be taken on Field Trips

If there are questions regarding this medication I authorize the School Nurse/District Nurse to contact ordering physician as needed throughout the school year.

It is the parent's responsibility to pick up medications that are no longer needed at school. Medications that have expired and/or are discontinued during the school year will be disposed of within a week of the expiration or discontinuation date. At the end of the school year left over or unused medications will be disposed of immediately after the last day of school.

Signature of Parent/Guardian (**REQUIRED**) \_\_\_\_\_ Date \_\_\_\_\_

Physician signature (**REQUIRED**) \_\_\_\_\_ Date \_\_\_\_\_

Physician's Official Stamp

# PARENT VOLUNTEER FORM

2026 - 2027 Yearly Band Paperwork

Student Name

Instrument

Grade

Parent/Guardian Name (mother)

Parent/Guardian Name (father)

Cell Phone (mother)

Cell Phone (father)

Email (mother)

Email (father)

**Please indicate if one (or both) parents can help in any of the following areas:**

*(M=Mother, F=Father)*

FUNDRAISING	<input type="checkbox"/> M	<input type="checkbox"/> F	CARPENTRY	<input type="checkbox"/> M	<input type="checkbox"/> F
PUBLIC RELATIONS	<input type="checkbox"/> M	<input type="checkbox"/> F	WELDING	<input type="checkbox"/> M	<input type="checkbox"/> F
FIRST AID	<input type="checkbox"/> M	<input type="checkbox"/> F	PHOTOGRAPHY	<input type="checkbox"/> M	<input type="checkbox"/> F
UNIFORMS	<input type="checkbox"/> M	<input type="checkbox"/> F	BAKING	<input type="checkbox"/> M	<input type="checkbox"/> F
EQUIPMENT MOVING	<input type="checkbox"/> M	<input type="checkbox"/> F	SEWING	<input type="checkbox"/> M	<input type="checkbox"/> F
OFFICE HELP	<input type="checkbox"/> M	<input type="checkbox"/> F	TELEPHONE TREE	<input type="checkbox"/> M	<input type="checkbox"/> F
NOTARY	<input type="checkbox"/> M	<input type="checkbox"/> F	MERCHANDISING	<input type="checkbox"/> M	<input type="checkbox"/> F
TRUCK/TRAILER DRIVER	<input type="checkbox"/> M	<input type="checkbox"/> F	PRINTING	<input type="checkbox"/> M	<input type="checkbox"/> F
CHAPERONE	<input type="checkbox"/> M	<input type="checkbox"/> F	GRAPHIC DESIGN	<input type="checkbox"/> M	<input type="checkbox"/> F
PAINTING	<input type="checkbox"/> M	<input type="checkbox"/> F	ELECTRICIAN	<input type="checkbox"/> M	<input type="checkbox"/> F
PLUMBING	<input type="checkbox"/> M	<input type="checkbox"/> F	OTHER: _____	<input type="checkbox"/> M	<input type="checkbox"/> F

**Please indicate if you have any contacts with people in the following areas:**

COSTUMES	<input type="checkbox"/> M	<input type="checkbox"/> F	LODGING	<input type="checkbox"/> M	<input type="checkbox"/> F
FABRIC SALES	<input type="checkbox"/> M	<input type="checkbox"/> F	PRINTING/OFFICE SERVICE	<input type="checkbox"/> M	<input type="checkbox"/> F
RESTAURANTS	<input type="checkbox"/> M	<input type="checkbox"/> F	TRANSPORTATION	<input type="checkbox"/> M	<input type="checkbox"/> F
ELEMENTARY SCHOOL	<input type="checkbox"/> M	<input type="checkbox"/> F	MIDDLE SCHOOL	<input type="checkbox"/> M	<input type="checkbox"/> F

**All volunteers MUST be an approved Lake County Schools Level 2 Volunteer.**



Scan the QR Code to sign up today! Your volunteer status lasts three years and it is FREE to register! Please make sure you email Mr. Yannick Innis ([InnisY@lake.k12.fl.us](mailto:InnisY@lake.k12.fl.us)) and the UHS Volunteer Coordinator, Ms. Stephanie Caruso ([CarusoS@lake.k12.fl.us](mailto:CarusoS@lake.k12.fl.us)), once you have completed [your online volunteer application](#). Volunteer applicants must also fill out the attached VECHS Volunteer Agreement.

School Name: \_\_\_\_\_

**VECHS APPLICANT**  
**WAIVER AGREEMENT**  
**AND STATEMENT**

For Criminal History Record Checks

This form shall be completed and signed by every current or prospective employee and/or volunteer.

I hereby authorize (enter Name of Qualified Entity) \_\_\_\_\_ Lake County Schools to submit a set of my fingerprints and this form to the Florida Department of Law Enforcement (FDLE) for the purpose of accessing and reviewing Florida and national criminal history records that may pertain to me. I understand that I would be able to receive any national criminal history record that may pertain to me directly from the Federal Bureau of Investigation (FBI). Pursuant to Title 28, Code of Federal Regulations (CFR), Sections 16.30-16.34 and that I could then freely disclose any such information to whomever I chose. By signing this Waiver Agreement, it is my intent to authorize the dissemination of any national criminal history record that may pertain to me to the Qualified Entity with which I am or am seeking to be employed or to serve as a volunteer.

I understand that my fingerprints may be retained at FDLE and the FBI for the purpose of providing any subsequent arrest notifications and that upon request you may provide me a copy of the criminal history record report, and that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I am aware that procedures for obtaining a change, correction, or updating of the FDLE or FBI criminal history are set forth in F.S. 943.056 and Title 28, CFR, Section 16.34. I may obtain a prompt determination as to the validity of my challenge before you make a final decision about my status as an employee and/or volunteer.

A national criminal history record check has previously been requested by:

\_\_\_\_\_  
(Name and Address of Previous Qualified Entity)

\_\_\_\_\_  
(Year of Request)

I  have OR  have not been convicted of a crime.

If convicted, describe the crime(s) and the particulars of the conviction(s) in the space below:

\_\_\_\_\_  
I  do OR  do not authorize you to release my criminal history records, if any, to other qualified entities.

I am a current or prospective (check one):  Employee  Volunteer  Coach Volunteer

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

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

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**TO BE COMPLETED BY QUALIFIED ENTITY:**

Entity Name: Lake County Schools - Human Resources

Address: 201 West Burleigh Boulevard

City: Tavares

Zip Code: 32778

Email: [onlineapplication@lake.k12.fl.us](mailto:onlineapplication@lake.k12.fl.us)

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**ORIGINAL- MUST BE RETAINED BY QUALIFIED ENTITY**

# SUMMER CONTACT INFO

2026 - 2027 Yearly Band Paperwork

Yes... we are asking you to fill out your contact info yet again. Thanks for understanding the importance of having valid email addresses and phone numbers on file! Communication is key, and the UHS Band is committed to keeping everyone well-informed and up-to-date, even in the summer!

Please fill out this digital Summer Contact Info form ASAP. Thank you!



# SPORTS PHYSICAL FORMS

## 2026 - 2027 Yearly Band Paperwork

Per UHS & Lake County Schools, all students enrolled in Marching Band and Colorguard need to complete an annual Sports Physical. **THIS MUST BE COMPLETED BY JULY 1, 2026!** Follow these quick steps to learn how to complete and upload your Sports Physical.



1. Set up a profile on the [Athletic Clearance website](#)
2. Click “Add new clearance” and follow steps.
  - If you have previously created an account, sign in with that username/password.
  - Watch [tutorial video](#) if help is needed
3. Choose school year (2026-27)
4. Choose school: Umatilla will be toward the bottom of the list, it goes in alphabetical order
5. Choose sport: Please include all sports your child is interested in playing, even if they’re not sure they will play. Select a sport then click “add new sport” until you are done listing them.
6. Athlete and Parent/Guardian information will need to be completed. Please answer all questions.
7. Health insurance is required for participation in all sports. If you need to purchase insurance for your child, please direct questions to Deta Brunson (Athletic Director) or Jordan Rowell (Athletic Trainer)
8. The concussion, heat illness, and sudden cardiac arrest videos are required for all athletes. Please make sure to upload completed certificates once finished.
9. Once you have fully completed the athletic clearance registration process, your athlete’s information will be sent to the UHS Athletic Department for review. When the student has been cleared for participation, an email will be sent to the email address you created the account with.
10. Please be on the lookout for a reply email letting you know if your child has been cleared to participate. If your clearance is denied, the email will explain what needs to be addressed before your child can be cleared.
11. There are **(2) TWO FORMS** attached! All students that are “**NEW to Umatilla High School**” will need to complete the **EL1 (ECG Form) & EL2 (Physical Evaluation Form)**. All “**Returning UHS MEMBERS**” students only need to complete the **EL2 (Physical Evaluation Form)**.





**ELECTROCARDIOGRAM (ECG) SCREENING (Page 1 of 1)**  
SUBMIT THIS CLEARANCE FORM TO THE SCHOOL

**EL1**

Revised 2/26

**ELECTROCARDIOGRAM (ECG) SCREENING FORM**

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

Student's Full Name: \_\_\_\_\_ Biological Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Student ID: \_\_\_\_\_

**Parent/Guardian:** Review the FHSAA EL3 Consent and Release form for details on Sudden Cardiac Arrest. Per §1006.20, F.S. (Second Chance Act), effective July 1, 2026, all first-time high school participants in FHSAA athletics must have an Electrocardiogram (ECG) screening before participation. This applies to students with no cardiac symptoms. Students with cardiac symptoms should consult their healthcare provider. An ECG completed within two (2) years prior to July 1 of the participation year satisfies this requirement. If the ECG requires further evaluation, the student must be cleared by a licensed medical practitioner trained in the diagnosis, evaluation and management of ECGs before participating in FHSAA athletic competition, practice, tryouts, or workouts.

**Please complete only ONE section (Section A or Section B, as applicable)**

**SECTION A: PARENT/GUARDIAN ATTESTATION (Select one and sign below)**

ECG completed by Who We Play For, a hospital in the state of Florida, or another healthcare organization and electronically signed by a licensed physician; attach normal result documentation from health record or the email received from provider.

**Date of NORMAL ECG Result:** \_\_\_/\_\_\_/\_\_\_ **Organization Performing ECG:** \_\_\_\_\_

OR

Medical Exception - Attach FHSAA Form ME1

Religious Objection - I object to an ECG for my child based on religious reasons allowed by law

**Parent/Guardian Signature:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**SECTION B: LICENSED PRACTITIONER ATTESTATION - ECG Interpretation by healthcare provider**

In accordance with §1006.20(2)(c), F.S., I certify I am a licensed practitioner (Ch. 458, 459, 460, 464.012, 464.0123 F.S. or equivalent) familiar with the "International Criteria for ECG interpretation in student-athletes". If the ECG is normal, complete the section below. If further evaluation is required, the student should be referred to a practitioner trained in the diagnosis, evaluation and management of ECGs.

Normal ECG (no additional evaluation required)

Normal variant ECG based on the International Criteria (no additional evaluation required)

Further evaluation by a licensed medical professional is required, and an EL1/2S must be completed

**Provider Signature:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**Credentials:** \_\_\_\_\_ **License#:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

*If your ECG requires further evaluation and you need help accessing cardiology follow-up care, please visit [www.whoweplayfor.org](http://www.whoweplayfor.org).*

**Please retain a copy for your records.**



## PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

*This medical history form should be retained by the healthcare provider and/or parent.*

*This form is valid for 365 calendar days from the date of exam.*

**EL2**

**Revised 2/26**

### MEDICAL HISTORY FORM

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

Student's Full Name: \_\_\_\_\_ Biological Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_

Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

Family Healthcare Provider: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

List past and current medical conditions:

Have you ever had surgery? If yes, please list all surgical procedures and dates:

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

#### Patient Health Questionnaire version 4 (PHQ-4)

*Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)*

	Not at all	Several days	Over half of the days	Nearly everyday
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

GENERAL QUESTIONS		Yes	No	HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.				<i>(continued)</i>			
1	Do you have any concerns that you would like to discuss with your provider?			8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
2	Has a provider ever denied or restricted your participation in sports for any reason?			9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
3	Do you have any ongoing medical issues or recent illnesses?			10	Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No
4	Have you ever passed out or nearly passed out during or after exercise?			11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash)		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			12	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?						
7	Has a doctor ever told you that you have any heart problems?			13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

**This form is not considered valid unless all sections are complete.**



**PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)**

*This medical history form should be retained by the healthcare provider and/or parent.*

*This form is valid for 365 calendar days from the date of exam.*

**EL2**

Revised 2/26

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ School: \_\_\_\_\_

BONE AND JOINT QUESTIONS		Yes	No	MEDICAL QUESTIONS (continued)		Yes	No
14	Have you ever had a stress fracture?			26	Do you worry about your weight?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			27	Are you trying to or has anyone recommended that you gain or lose weight?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?			28	Are you on a special diet or do you avoid certain types of foods or food groups?		
MEDICAL QUESTIONS		Yes	No	29	Have you ever had an eating disorder?		
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?			Explain "Yes" answers here: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____			
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?						
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?						
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?						
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?						
22	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?						
23	Have you ever become ill while exercising in the heat?						
24	Do you or does someone in your family have sickle cell trait or disease?						
25	Have you ever had or do you have any problems with your eyes or vision?						

**This form is not considered valid unless all sections are complete.**

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. Florida Statute 1006.20 requires a student candidate for an interscholastic athletic team to successfully complete a preparticipation physical evaluation as the first step of injury prevention. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine physical evaluation required by Florida Statute 1006.20, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test. The FHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: \_\_\_\_\_ (printed) Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Parent/Guardian Name: \_\_\_\_\_ (printed) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Parent/Guardian Name: \_\_\_\_\_ (printed) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_



## PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)

*This medical history form should be retained by the healthcare provider and/or parent.*

*This form is valid for 365 calendar days from the date of exam.*

**EL2**

**Revised 2/26**

### PHYSICAL EXAMINATION FORM

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ School: \_\_\_\_\_

#### HEALTHCARE PROFESSIONAL REMINDERS:

Consider additional questions on more sensitive issues.

<ul style="list-style-type: none"> <li>Do you feel stressed out or under a lot of pressure?</li> </ul>	<ul style="list-style-type: none"> <li>Do you ever feel sad, hopeless, depressed, or anxious?</li> </ul>
<ul style="list-style-type: none"> <li>Do you feel safe at your home or residence?</li> </ul>	<ul style="list-style-type: none"> <li>During the past 30 days, did you use chewing tobacco, snuff, or dip?</li> </ul>
<ul style="list-style-type: none"> <li>Do you drink alcohol or use any other drugs?</li> </ul>	<ul style="list-style-type: none"> <li>Have you ever taken anabolic steroids or used any other performance-enhancing supplement?</li> </ul>
<ul style="list-style-type: none"> <li>Have you ever taken any supplements to help you gain or lose weight or improve your performance?</li> </ul>	<ul style="list-style-type: none"> <li>Have you experienced performance changes, felt fatigued, and/or experienced times of low energy during the past year?</li> </ul>

Verify completion of FHSAA EL2 Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

#### EXAMINATION

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

**BP:** \_\_\_ / \_\_\_ ( \_\_\_ / \_\_\_ ) **Pulse:** \_\_\_\_\_ **Vision:** R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ **Corrected:** Yes No

MEDICAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
<b>Appearance</b> <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
<b>Eyes, Ears, Nose, and Throat</b> <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
<b>Lymph Nodes</b>		
<b>Heart</b> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)</li> </ul>		
<b>Lungs</b>		
<b>Abdomen</b>		
<b>Skin</b> <ul style="list-style-type: none"> <li>Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis</li> </ul>		
<b>Neurological</b>		

MUSCULOSKELETAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
<b>Neck</b>		
<b>Back</b>		
<b>Shoulder and Arm</b>		
<b>Elbow and Forearm</b>		
<b>Wrist, Hand, and Fingers</b>		
<b>Hip and Thigh</b>		
<b>Knee</b>		
<b>Leg and Ankle</b>		
<b>Foot and Toes</b>		
<b>Functional</b> <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>		

**This form is not considered valid unless all sections are complete.**

\*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. The FHSAA Sports Medicine Advisory Committee strongly recommends to a student-athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.

Name of Healthcare Professional (print or type): \_\_\_\_\_ Date of Exam: \_\_\_ / \_\_\_ / \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Signature of Healthcare Professional: \_\_\_\_\_ Credentials: \_\_\_\_\_ License #: \_\_\_\_\_



# PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date of exam.

**EL2**

Revised 2/26

## MEDICAL ELIGIBILITY FORM

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

Student's Full Name: \_\_\_\_\_ Biological Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
 School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
 Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_  
 Family Healthcare Provider: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

### SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp (if required by school)

Medications: (use additional sheet, if necessary)

List: \_\_\_\_\_

Relevant medical history to be reviewed by athletic trainer/team physician: (explain below, use additional sheet, if necessary)

- Allergies  Asthma  Cardiac/Heart  Concussion  Diabetes  Heat Illness  Orthopedic  Surgical History  Sickle Cell Trait  Other

Explain: \_\_\_\_\_

Signature of Student: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct. We understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test.

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction after clearance by medical specialist for: \_\_\_\_\_  
(If this option is checked, additional medical follow-up and clearance prior to sports participation is required. Use Form EL1/2S for documentation.)
- Medically eligible for only certain sports as listed below: \_\_\_\_\_
- Not medically eligible for any sports

Recommendations: (use additional sheet, if necessary)

In accordance with §1006.20(2)(c), F.S., I hereby certify that I am a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with my regulatory board, or a practitioner who holds an active equivalent licensure issued by the state in which the medical evaluation was performed and that I, or a clinician under my direct supervision, have examined the above-named student-athlete using the FHSAA EL2 Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): \_\_\_\_\_ Date of Exam: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Signature of Healthcare Professional: \_\_\_\_\_ Credentials: \_\_\_\_\_ License #: \_\_\_\_\_

**This form is not considered valid unless all sections are complete.**