UMATLLA HIGH SCHOOL

BULLDOG BAND

All band paperwork is due on <u>JULY 26</u>
(before band camp begins).

☐ Band Fee Commitment	*with $75 commitment & camp fee*
☐ Band Contract	*signed*
☐ Uniform Contract	*signed*
☐ Student Info Form	*with valid email address*
☐ **LCS Waiver & FT Form**	***NOTARIZED***
☐ Medical/Prescription Release Form	*signed by a doctor*
☐ Non-Medical Release Form	*optional*
☐ Parent Volunteer Form	*with the VECHS Agreement*
☐ Summer Contact Info	*online*
☐ **Sports Physical Paperwork**	***due online by July 1st!***

2025 - 2026

yearly paperwork

BAND FEE COMMITMENT

2025 - 2026 Yearly Band Paperwork

Yearly Band Fees **$275 total**

All payments will be done through the UHS School Store online payment will be available soon.

☐	**$25**	**Commitment Fee**	**August 1**
☐	**$50**	**Band Camp Fee**	**August 1**
☐	$50	Band Fee Payment #1	October 10
☐	$50	Band Fee Payment #2	December 19
☐	$50	Band Fee Payment #3	March 5
☐	$50	Band Fee Payment #4	May 29

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

2025 - 2026 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

2025 - 2026 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 2025 – 2026 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

2025 - 2026 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

2025 - 2026 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.)

FIELD TRIP FORM

2025 - 2026 Yearly Band Paperwork

LAKE COUNTY SCHOOLS

FIELD TRIP/SCHOOL ACTIVITY
PARENT CONSENT/LIABILITY WAIVER/MEDICAL RELEASE

[■] OVERNIGHT
[■] OUT-OF-STATE
[■] OFF CAMPUS

Student _____ School Umatilla High School
Club/Group/Class Band Supervising Faculty Member Yannick Innis
Activity Band Events (see attached for specific details) Location Band Events (see attached for specific details)
Date & Time of Departure Band Events (see attached for specific details) Date & Time of Return Band Events (see attached for specific details)
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 UHS BAND EVENTS 2025 - 2026 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

2025 - 2026 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 Umatilla High School

Address _____

Home Phone _____ Work _____

Name of medication _____

Dosage to be given _____ Time to be given _____

Diagnosis _____ Allergies _____

Date to start July 26, 2025 Last date to be given May 29, 2026

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

2025 - 2026 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 Asprin, Benadryl, Ibuprofen, Tylenol

Dose to be given Per dosage on bottle Time(s) to be given As needed

Diagnosis _____ Allergies _____

Purpose/reason for this medication As needed - call before administering

Discontinue date July 26, 2025 - May 29, 2026

Instruction(s) (i.e. take with water, milk, food) Take with water & 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

SCHOOL: Umatilla High School

PARENT VOLUNTEER FORM

2025 - 2026 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	☐ M	☐ F	CARPENTRY	☐ M	☐ F
PUBLIC RELATIONS	☐ M	☐ F	WELDING	☐ M	☐ F
FIRST AID	☐ M	☐ F	PHOTOGRAPHY	☐ M	☐ F
UNIFORMS	☐ M	☐ F	BAKING	☐ M	☐ F
EQUIPMENT MOVING	☐ M	☐ F	SEWING	☐ M	☐ F
OFFICE HELP	☐ M	☐ F	TELEPHONE TREE	☐ M	☐ F
NOTARY	☐ M	☐ F	MERCHANDISING	☐ M	☐ F
TRUCK/TRAILER DRIVER	☐ M	☐ F	PRINTING	☐ M	☐ F
CHAPERONE	☐ M	☐ F	GRAPHIC DESIGN	☐ M	☐ F
PAINTING	☐ M	☐ F	ELECTRICIAN	☐ M	☐ F
PLUMBING	☐ M	☐ F	OTHER: _____	☐ M	☐ F

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

COSTUMES	☐ M	☐ F	LODGING	☐ M	☐ F
FABRIC SALES	☐ M	☐ F	PRINTING/OFFICE SERVICE	☐ M	☐ F
RESTAURANTS	☐ M	☐ F	TRANSPORTATION	☐ M	☐ F
ELEMENTARY SCHOOL	☐ M	☐ F	MIDDLE SCHOOL	☐ M	☐ 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) and the UHS Volunteer Coordinator, Ms. Stephanie Caruso (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: Umatilla High School

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: _____

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

ORIGINAL- MUST BE RETAINED BY QUALIFIED ENTITY

SUMMER CONTACT INFO

2025 - 2026 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

2025 - 2026 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, 2025!** 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 (2025-26)
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.

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 signed below.

EL2

Revised 4/24

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 Questionaire 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 Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.	Yes	No
1	Do you have any concerns that you would like to discuss with your provider?		
2	Has a provider ever denied or restricted your participation in sports for any reason?		
3	Do you have any ongoing medical issues or recent illnesses?		
	HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4	Have you ever passed out or nearly passed out during or after exercise?		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
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?		

	HEART HEALTH QUESTIONS ABOUT YOU *(continued)*	**Yes**	**No**
8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10	Have you ever had a seizure?		
	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
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)		
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 catecholaminerigc polymorphic ventricular tachycardia (CPVT)?		
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 signed below.

EL2

Revised 4/24

Student's Full Name: _____ Date of Birth: ___ /___ /_____ School: _____

BONE AND JOINT QUESTIONS		Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		

MEDICAL QUESTIONS		Yes	No
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
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?		

MEDICAL QUESTIONS *(continued)*		Yes	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that you gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

Explain "Yes" answers here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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: ___ / ___ / ___

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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 signed below.

EL2
Revised 4/24

PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ___ /___ /_____ School: _____

HEALTHCARE PROFESSIONAL REMINDERS:

Consider additional questions on more sensitive issues.

• Do you feel stressed out or under a lot of pressure?	• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Do you drink alcohol or use any other drugs?	• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	• Have you experienced performance changes, felt fatigued, and/or experienced times of low energy during the past year?

☐ 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
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, Ears, Nose, and Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis		
Neurological		

MUSCULOSKELETAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and Arm		
Elbow and Forearm		
Wrist, Hand, and Fingers		
Hip and Thigh		
Knee		
Leg and Ankle		
Foot and Toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

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 #: _____

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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 signed below.

EL2

Revised 4/24

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: (_____) _____

The preparticipation physical evaluation must be administered by a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with the practitioner's regulatory board. (§1006.20(2)(c), F.S.)

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

_____

I hereby certify 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 #: _____

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.

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

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PREPARTICIPATION PHYSICAL EVALUATION (Supplement)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/24

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

MEDICAL ELIGIBILITY FORM - Referred Provider 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: (_____) _____

Referred for: _____ Diagnosis: _____

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

☐ Medically eligible for all sports without restriction as of the date signed below

☐ Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Further Recommendations: *(use additional sheet, if necessary)*

_____

Name of Healthcare Professional (print or type): _____ Date of Exam: ___ / ___ / _____

Address: _____ Phone: (_____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*