2018-2019

HEALTH SERVICES FORMS

PLEASE SUBMIT BACK TO IMG ACADEMY FIVE WEEKS PRIOR TO ARRIVAL.

EMAIL: FORMS@IMG.COM
FAX: (941) 752-2630

TABLE OF CONTENTS AND CHECKLIST

In order to complete the Academy Program enrollment process and confirm your space at IMG Academy, all forms must be completed, signed and returned. Many forms require a signature from both parent/guardian and participant.

PLEASE USE THE TABLE OF CONTENTS AS A CHECKLIST TO ENSURE ALL FORMS ARE COMPLETED AND RETURNED FIVE WEEKS PRIOR TO ARRIVAL.
EMAIL: FORMS@IMG.COM / FAX: (941) 752-2630

- ☐ Participant Health Records (All Participants)........ P2-P3
- ☐ Physician's Report (All Participants)........ P4-P5
- ☐ Immunization Record (All New Participants)........ P6
- ☐ General Health Care Policies (All Participants)........ P7-8
- ☐ Medication Policy and Consent (Boarding Participants Only)........ P9
- ☐ Consent for Treatment (All Participants)........ P10
- ☐ Emergency Contacts (All Participants)........ P10
- ☐ Health Insurance Requirements (All Participants)........ P11
- ☐ Parent/Guardian Consent for Permitted Supplement Use (All Participants)..... P13
- ☐ Johns Hopkins All Children's Hospital Forms (All Participants)........ P14-17
- ☐ FHSAA Forms (Baseball, Basketball, Football, Track, and Lacrosse Only; See Below)........ P18-24

In order to be eligible for participation in teams for schools that belong to the Florida High School Athletic Association (FHSAA), the FHSAA requires that the Preparticipation Physical Evaluation form (EL2) be completed for all baseball, basketball, football, lacrosse, or track & field/cross country student-athletes.

In addition to the Preparticipation Physical Evaluation (EL2), the following additional FHSAA forms (included in this packet) must also be completed and submitted by student-athletes who compete in: The FSHAA Consent and Release from Liability Certificate (EL3). Please complete, sign, and submit the FHSAA forms along with the completed IMG Academy health forms provided in this packet.

PARTICIPANT HEALTH RECORDS

PLEASE NOTE: THIS FORM MUST BE COMPLETED IN ENGLISH. THE PARTICIPANT HEALTH RECORDS/PHYSICIAN'S REPORT FORMS ARE DUE ANNUALLY. THIS PAGE IS TO BE COMPLETED BY THE PARENT/GUARDIAN.

Participant Name: ______________________ **Date of Birth:** ____________ **Sport:** ______________

Gender: ________ **Housing:** __________ **Participant Cell Phone:** ______________________

Does your child have any known allergies to food/medicine/other? ☐ No ☐ Yes, my child is allergic to: ______________

What treatment should be given in the event of an allergic reaction? ______________________

Has your child ever had to use an EpiPen? ☐ No ☐ Yes **Does your child carry an EpiPen?** ☐ No ☐ Yes

HEALTH HISTORY:

If the Participant has a chronic medical condition such as asthma, diabetes, seizure disorder, hemophilia, severe allergies or a mental health disorder, please contact Health Services at 941-752-2479 to discuss these requirements prior to enrolling or making any travel arrangements to IMG Academy.

01	Diabetes Type: ______________	Date: ________	☐ Yes	☐ No
02	Asthma/Bronchitis Comments: ______________	Date: ________	☐ Yes	☐ No
	a. If Yes, has your child: Been on oral steriods in the past year?	Date: ________	☐ Yes	☐ No
	b. Been to the emergency room in the past year for asthma?	Date: ________	☐ Yes	☐ No
	c. Been admitted to the hospital for an overnight stay in the last year?	Date: ________	☐ Yes	☐ No
03	Does the Participant cough, wheeze, or have trouble breathing during or after activity?	Date: ________	☐ Yes	☐ No
04	Epilepsy/Seizure Disorder Comments: ______________	Date: ________	☐ Yes	☐ No
05	Has the Participant ever had a diagnosed concussion?	Date: ________	☐ Yes	☐ No
	a. If YES, how many? ______________			
	b. Within last 6 months, provide documentation of event and include doctor's clearance.			
06	Has the Participant ever experienced unconsciousness, memory loss or had a seizure as a result of a head injury?	Date: ________	☐ Yes	☐ No
07	Mononucleosis Comments: ______________	Date: ________	☐ Yes	☐ No
08	Has the Participant or any family member ever had an adverse reaction to anesthesia (ex. malignant hyperthermia)?	Date: ________	☐ Yes	☐ No
09	Does the Participant have a history of or currently have an eating disorder?	Date: ________	☐ Yes	☐ No
10	Does the Participant have a history of or currently have any mental health issues (ex. depression, anxiety, stress, ADD/ADHD)?	Date: ________	☐ Yes	☐ No
	a. Does the Participant take medication related to a mental health issue? (ex. anti-depressant, anti-anxiety, ADD/ADHD medications)?	Date: ________	☐ Yes	☐ No
	b. If YES, what medications? ______________			
11	Has the Participant ever been referred/evaluated by a psychiatrist/psychologist?	Date: ________	☐ Yes	☐ No
12	Pneumonia Comments: ______________	Date: ________	☐ Yes	☐ No
13	Sinusitis Comments: ______________	Date: ________	☐ Yes	☐ No
14	Tonsillitis Comments: ______________	Date: ________	☐ Yes	☐ No
15	Does the Participant have painful menstrual cycles? How is it treated? ______________		☐ Yes	☐ No
16	Does the Participant have any current skin problems (ex. itching, rashes, acne, warts, fungus)?	Date: ________	☐ Yes	☐ No
17	Does the Participant have frequent or severe headaches or migraines?	Date: ________	☐ Yes	☐ No
18	Has the Participant ever had numbness or tingling in their arms, hands, legs, or feet?	Date: ________	☐ Yes	☐ No
19	Does your child take any medication by injection? If yes, provide the name of the medication and the reason: ______________ Please call Health Services to discuss prior to arrival at (941) 752-2479.	Date: ________	☐ Yes	☐ No

Explain "YES" Answers: ____

____

PARTICIPANT HEALTH RECORDS

Participant Name: ______________________________

THIS PAGE IS TO BE COMPLETED BY THE PARENT/GUARDIAN

SURGERIES OR HOSPITALIZATIONS:
List any surgeries or hospitalizations:

DATE	SURGERY	HOSPITALIZATION

CURRENT MEDICATIONS & SUPPLEMENTS:
Please list all medications, supplements and their dosages (including over-the-counter medications and supplements) that the Participant is taking:

MEDICATION	DOSAGE	INSTRUCTIONS

MEDICATION & SUPPLEMENT REQUIREMENTS:
Please refer to the Medication Policy and Consent for Boarding Participants and the IMG Academy Participant Supplement Policy.

ORTHOPEDIC HISTORY
Please provide any previous injuries the Participant has suffered: Include dates, surgeries, special tests (CAT scan, x-ray, MRI, etc), right or left body part.

Head (Including ear, teeth, nose, and eyes):		Wrists:	
Neck:		Hands/Fingers:	
Back:		Thighs:	
Chest:		Knee:	
Shoulders:		Lower Leg (shin/calves):	
Arms:		Ankles:	
Elbows:		Feet/Toes:	

Is there anything else we should be aware of regarding the Participant's health?

____

____

____

I hereby state, to the best of my knowledge, my answers to the above questions are complete and correct. I understand and acknowledge that I am hereby advised that the Participant should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECHO) and/or cardio stress test. If any of the above tests are performed on your Participant, please include a copy with this form.

______________________________ Signature of Parent/Guardian

______________________________ Date of Completion

______________________________ Please Print Name

PHYSICIAN'S REPORT

Participant Name: ______________________________

PHYSICIAN'S REPORT - MUST BE COMPLETED BY PHYSICIAN IN ENGLISH

Based upon Florida statutes, any health professional who is licensed in Florida or the state/country the student resided in at the time of the health examination and who is authorized to perform a general health examination under such licensure shall be acceptable to complete the Physician's Report. A health professional includes an individual who is a licensed M.D., D.O., Physician's Assistant/P.A., or Nurse Practitioner/ARNP.

EXAMINATION DATE: ____________________

RECENT ORTHOPEDIC HISTORY (required)

1. Has the Participant had any orthopedic injuries within the last six months? ☐ Yes ☐ No Date: ______________________
   a. If YES, please specify the injury: ______________________
   b. If YES, does the Participant have clearance to resume participation in sport in returning from the injury? ☐ Yes ☐ No

RECENT CONCUSSION HISTORY (required)

1. Has the Participant had a diagnosed concussion within the last six months? ☐ Yes ☐ No Date: ______________________
   a. If YES, does the Participant have clearance to resume participation in sport in returning from the concussion? ☐ Yes ☐ No

PHYSICAL EXAM

Describe any variations from the norm N = Normal Ab = Abnormal

Teeth:	Scalp:	GI System:
Glands:	Extremities:	Vital Signs:
Lungs:	Eyes:	Menses:
Skin:	Ears:	Chest X-Ray:
Heart:	Abdomen:	Other:
Abnormal explained:		

SCREENING TESTS

Height:	Weight:	BP:	P:	
Vision Distance Acuity:	Right ________	Left ________	With Correction	Wears Glasses ☐ Yes ☐ No
	Right ________	Left ________	Without Correction	Wears Contacts ☐ Yes ☐ No

TUBERCULOSIS SCREENING (MANTOUX PPD SKIN TEST)

Have you been experiencing any of the following signs and symptoms that may be associated with tuberculosis?
(Anyone with a "Yes" response will require a TB test or chest x-ray)

1. Persistent Cough (>3 weeks)	☐ Yes	☐ No	6. Night Sweats	☐ Yes	☐ No
2. Coughing up Blood	☐ Yes	☐ No	7. Tire Easily	☐ Yes	☐ No
3. Unexplained Weight Loss	☐ Yes	☐ No	8. Have you ever had a positive TB skin test?	☐ Yes	☐ No
4. Loss of Appetite	☐ Yes	☐ No	9. Have you ever taken prophylactic medication because you were exposed to TB?	☐ Yes	☐ No
5. Fever/Chills	☐ Yes	☐ No			

Date of Test:	Date Read:	2nd Test Required: ☐ Yes ☐ No
Site:	Results in MM:	Date of 2nd Test:
By:	By:	Site:
Manufacturer:		By:
Lot #:	Results in MM:	Expiration Date:

PHYSICIAN'S REPORT

Participant Name: ______________________________

PHYSICIAN'S REPORT - MUST BE COMPLETED BY PHYSICIAN IN ENGLISH

CARDIAC EVALUATION

IMG Academy has adopted the American Heart Association's Recommendations for Pre-Participation Screening. **For "yes" answers Participants must provide a letter of clearance from a cardiologist prior to Participant's travel to IMG.** *Personal Medical History and Family Medical History sections may be completed by a parent/guardian. Please contact the Enrollment Office at (941) 752-2445 with any questions.*

PERSONAL MEDICAL HISTORY (Please see above for any "Yes" response)			COMMENTS
Exertional chest pain/discomfort	☐ Yes	☐ No	
Unexplained Syncope (Fainting)	☐ Yes	☐ No	
Excessive exertional and otherwise unexplained dyspnea (shortness of breath)/fatigue associated with exercise	☐ Yes	☐ No	
Elevated blood pressure	☐ Yes	☐ No	
Has the participant been restricted from participation in sports for any reason other than injury?	☐ Yes	☐ No	
Has the participant had prior cardiac testing for ordered by a health care provider?	☐ Yes	☐ No	

FAMILY MEDICAL HISTORY (Please see above for any "Yes" response)			COMMENTS
Premature death (sudden or otherwise) related to heart disease in first or second degree relatives younger than 50 years (Parents, siblings, grandparents, aunts/uncles, nephews/nieces, or half-siblings).	☐ Yes	☐ No	
Disability from heart disease in a first or second degree relative younger than 50 years (Parents, siblings, grandparents, aunts/uncles, nephews/nieces, or half-siblings).	☐ Yes	☐ No	
Specific knowledge of hypertrophic or dilated cardiomyopathy, ion channelopathies such as long QT syndrome, Marfan Syndrome, or clinically important arrhythmias in any relative.	☐ Yes	☐ No	

PHYSICAL EXAMINATION - MUST BE COMPLETED BY A HEALTH PROFESSIONAL (Please see above for any "Yes" response)			COMMENTS
Heart murmur	☐ Yes	☐ No	
Aortic Coarctation noted on Femoral Pulse Exam	☐ Yes	☐ No	
Physical stigmata of Marfan syndrome	☐ Yes	☐ No	
Abnormal Brachial artery blood pressure(sitting position)	☐ Yes	☐ No	

Additional information the examiner believes should be brought to the attention of IMG Academy to enable the Participant to participate in athletics or to provide for Participant's well being: ______________________________

____

I understand that IMG Academy programs may include vigorous physical activities and exertion, which can occur in the sunny, hot and humid environment in Florida. I have discussed both page 4 and page 5, including the "Cardiac Evaluation" (above), with the Participant and parents, performed a physical examination and believe he/she is physically able to participate in athletic and sports activities as described with unrestricted clearance.

Physician's Name (Print): ______________________________

Physician's Signature: ______________________________

Address: ______________________________ **Date:** ____________

City, State, Zip: ______________________________ **Phone: (   )** ____________

IMMUNIZATION RECORD

Participant Name: ______________________ **Date of Birth:** ______________

MUST BE COMPLETED IN ENGLISH. NEW PARTICIPANTS MUST COMPLETE IN FULL. RETURNING PARTICIPANTS SUBMIT UPDATES ONLY. All participants must have documented immunizations as recommended by the CDC (see below). Immunization documentation must be submitted and reviewed for completeness prior to attendance. If immunizations are not up to date at the time of arrival to IMG the Participant may be required to obtain immunizations at the Participant's cost in order to participate in programs or reside in participant housing. Immunizations can be obtained by the Participant's health care provider or the Health Department.

IMMUNIZATIONS	DATES RECEIVED (MM/DD/YYYY)				
DPT (diptheria, tetanus, pertussis) or TD (tetanus, diptheria) or DTP-Hib (5 required)					
Td (Tetanus)					
Polio: OPV, IPV (4th dose required if 3rd given before age 4)					
MMR (Mumps, Measles, Rubella) 2 doses required					
Hepatitis B (Series of 3 required)					
Varicella (Chicken Pox) required unless documented history of disease	Vaccine:	Vaccine:	Disease:		
Meningococcal					

2018-2019 SCHOOL ENTRY REQUIREMENTS

Prior to entry, attendance, or transfer to a Florida school (kindergarten through 12th grade) each child should have a completed Florida Certification of Immunization (schedule below), documenting the following:

— Four or five doses of diphtheria-tetanus-pertussis (DTaP) vaccine
— Two or three doses of hepatitis B (hep B) vaccine
— Four or five doses of polio vaccine*
— Two doses of measles-mumps-rubella (MMR) vaccine
— Two doses of varicella vaccine+ for kindergarten and grades one and two
— One dose of varicella vaccine+ for grades three through nine

*If fourth dose of vaccine is administered prior to the fourth birthday, a fifth dose of polio vaccine is required for entry into kindergarten.

+Varicella vaccine is not required if varicella disease is documented by the healthcare provider.

For more information, call (850) 245-4342 or visit WWW.IMMUNIZEFLORIDA.ORG

MENINGOCOCCAL VACCINE

I understand that the Meningococcal (Meningitis) vaccine is strongly recommended by the US Centers for Disease Control (CDC) for students.

☐ I wish to decline the Meningococcal vaccine for my child. I understand and accept the risks of my child not having this vaccine which can cause very severe illness and death.

☐ I will take my child to his/her local physician or Health Department to obtain the Meningococcal vaccine, and I will provide IMG Academy with proof of vaccination.

☐ My child has already received the Meningococcal vaccine, and the date is recorded above.

______________________________ ______________

Signature of Person Completing Immunization Record — Date of Completion

____

Please Print Name

GENERAL HEALTH CARE POLICIES

Participant Name (Please Print):____ **Date of Birth:** ______________________

A. Health Services and Illness

Health Services, staffed by Johns Hopkins All Children's Hospital employees, offers 24 hours a day nursing coverage. In addition to the nursing staff, Johns Hopkins All Children's Hospital operates a clinic staffed with physicians who are board certified in Pediatrics and Sports Medicine. Johns Hopkins All Children's Hospital also provides physical therapy services on campus. The medical and physical therapy staff have hours Monday through Friday. Appointments are made through referrals from the student's Athletic Trainer, nursing staff, or upon your request. Health Services can be reach at the follow:

Tel: (941) 752-2479

Fax (941) 752-2626

E-mail: HealthServices@img.com

Physical Therapy can be reached at (941)749-8780

B. Health Care Services

The scope of services Johns Hopkins staff provides differs between boarding and non-boarding participants.

HEALTH CARE SERVICES PROVIDED	BOARDING	NON-BOARDING
Emergency Care	X	X
Basic First Aid during school or program hours	X	Sick child must be picked up by parent/authorized adult within an hour of notification
Follow-up/monitoring as needed.	X	
Coordination of doctor appointments except for certain routine visits	X	
Administration of prescription medications	X	Emergency cases only (i.e. EpiPen) - and any medications that must be administered during set times and program hours.
Administration of Over The Counter medications	X	Parental approval at time of need or with Health Services consent

Boarding students requiring off-campus health care services:

Some medical conditions of boarding students may require off-campus testing and evaluation. For boarding students, these services will be coordinated through Health Services and the student will be transported and accompanied by a member of the Health Services team. If the student needs to see an off campus physician not referred by Johns Hopkins All Children's for other than routine care, please contact the LPN Care Coordinator at 941-752-2628 at least one week before the appointment in order to schedule and arrange for transportation. Any time off-campus care is necessary, a member of the Health Services team may contact the parents/guardians of the student for approval of the recommended service or appointment. If a student requires emergency care or urgent care services before the next available clinic appointment, these services may also be coordinated through Health Services.

When a boarding student requires routine off-campus follow-up for an ongoing condition with recurring off-campus appointments, such as appointments for dental, orthodontic, dermatology, vision, podiatrist or, chiropractic needs, or off-campus mental health appointments, the parent/guardian of the student must schedule such appointments and arrange for necessary transportation with the IMG Transportation Department. This can be done by emailing transportation@img.com or calling 941-840-8092. There is a fee for round trip transportation. A minimum of 48 hours notice is required and a failure to cancel with less than 24 hours or a no-show will result in the fee being charged.

Illness or injury requiring observation:

On occasion, observation in Health Services will be necessary for boarding participants with acute illness or injury. This service is available 24/7 for limited situations. Parents/Guardians will typically be notified by a member of the Heath Services team if their participant requires observation in Health Services. If after 24 hours of observation, a participant is still not able to reside within campus housing independently, parents/guardians will be notified and the participant may be required to go home or a parent/guardian may be required to provide care for the participant off-campus.

Medical observation for surgical procedures:

For the safety of participants, a parent or guardian is required to provide care off campus for any participants who have a surgical procedure with anesthesia or sedation. Parents/guardians must take the participant off campus the evening prior to the procedure. The participant will remain in the care of the parent or guardian for a minimum of 24 hours after the procedure. In order to return to campus the participant must be able to complete activities of daily living with minimal assistance. This includes ambulating from dorm room to the tram for transportation to school, meals, and other scheduled activities, showering or bathing, and other personal hygiene. Pain must be controlled without use of scheduled narcotic pain medication other than for occasional break through pain outside of school hours. A student should not return to campus if they are requiring narcotic pain control throughout the day. Parent/guardian and participant must check with Health Services for clearance back to campus when this criterion has been met. All medications must be checked into Health Services upon return to campus, along with surgical discharge instructions and follow up needs. Health Services does not provide long term convalescent care.

GENERAL HEALTH CARE POLICIES

C. Allergies

IMG Academy has developed the following guidelines for those students who suffer from food or other severe allergies.

Parents/Guardians should ensure that the student and Health Services are both aware of a treatment plan in the event of an allergy occurrence. Parents/guardians are expected to:

- Consult with student's private health care practitioner regarding appropriate management of student's allergies.
- Notify Health Services of the student's allergies and the prescribed treatments before arriving to campus.
- Ensure that the student is prepared to react when allergy symptoms are first evident. Students should carry their EpiPen or other treatments with them and have a second EpiPen in Health Services.
- Instruct students to always report to Health Services for any possible allergic reaction or possible exposure. The Health Services team is available on campus 24 hours a day, 7 days a week.
- Remind students that there is always the possibility of allergy exposures. Always be ready.

Students with severe food allergies or those who require special food arrangements must contact the Food & Beverage Department by calling 941-752-2491 sufficiently in advance of the student's arrival.

IMG Academy does not knowingly incorporate peanuts or tree nuts into foods served in the Campus Center. However, IMG Academy cannot prevent all cross-contamination during the food manufacturing, transport and service process. IMG Academy Golf and Country Club does incorporate nuts in its menu and at certain locations on campus prepackaged bars and snacks may have traces of nuts or may be made in factories with nuts. In addition, IMG Academy has no control over foods brought on Campus by caterers, food trucks, Chik-fil-a, other students, visitors, and guests.

D. Medications and Supplements

Please carefully read and sign the Medication Policy and Supplement Policy. These forms must be completed for boarding students even if your child is not currently taking medication or supplements

My signature below confirms that I have read and understand the above policies.

Parent/Guardian Signature	Printed Name	Date

MEDICATION POLICY AND CONSENT FOR BOARDING PARTICIPANTS

Parents and participants are required to provide IMG Academy and Johns Hopkin's All Children's with a current list of all medications, prescribed or over the counter, which the participant currently takes. For patient safety and medication security, it is our policy that Health Services administer prescription medication to participants. In certain situations, some medications and nutritional supplements (found on the permissible supplement list) are able to be self-administered and kept in the participant's room. The following medications fall into this category: emergency allergy control medication (EpiPens), topical creams, cleansers, eye drops, inhalers, nasal sprays, oral contraceptives, insulin, ibuprofen, non-sedating and non-decongestant antihistamines including: Zyrtec (Cetirizine), Claritin (Loratadine), and Allegra (fexofenadine), and throat lozenges/cough drops and other over the counter medications approved by Health Services. Participants must bring medications to Health Services. All permissible medications will be verified by Health Services and a permissible sticker will be placed on the bottle prior to the child being permitted to keep medication in their dorm room. Medications that are confiscated from a participant's dorm room that do not have a permissible sticker may be discarded by Health Services.

The following OTC medications are available in Health Services on an as needed basis and after a nursing assessment: Ibuprofen (Advil), Acetaminophen (Tylenol), Imodium, Pepto-Bismol, Tums, Simethicone, Diphenhydramine (Benadryl), Decongestant, Cepacol sore throat lozenges, cough drops, and Zyrtec (Ceterzine).

For those participants over the age of 18 years old, weekly medication planners/dispensers are allowed with the consent of Health Services. These will be prepared by Health Services. It is the responsibility of the participant to maintain them in a safe place and return to Health Services weekly when they require refilling. If any participant is non-compliant with this self-administration privilege, they will be required to come to Health Services for daily medication administration. Please contact Health Services at 941-752-2479 if you are requesting this service.

In addition to listing all medications here, please bring all prescription and over the counter medications to Health Services in original bottles, with original labeling (in English), at time of check in. All medications will be administered per the label instructions. If instructions have been modified, Health Services will require a note from the prescriber in order to administer the medication differently than the label instructions. Medication should be picked up at the end of the school year. Any medications left after one week of school closure will be destroyed.

Medication and Supplements	Reason for Medication	Administration directions	Prescriber	Prescriber contact information

Health Services expects the participants to report to Health Services for prescription medication at their assigned designated time.

If the Participant is required to take daily medication and is traveling off campus with IMG Academy staff, the medication will be dispensed to the coach, athletic trainer, or other staff in a travel pack. The team coach, trainer or other staff accompanying the Participant will provide the medication to the participant for administration while off campus.

By signing below, you acknowledge understanding of the medication policy for Participants as set forth above and consent to this medication administration.

Parent/Guardian Signature ______________________

Parent/Guardian Name (Please Print) ______________________

Participant Name (Please Print) ______________________

Date ______________________

CONSENT FOR TREATMENT & MEDICAL INSURANCE

CONSENT FOR TREATMENT

This is to certify that the staff of IMG Academy and Johns Hopkins All Children's Hospital (medical provider at IMG Academy) is being given authority by me, the custodial parent/legal guardian:

______________________________ of ______________________________
(Print Name of Parent or Guardian) (Print Name of Participant)

to arrange for any medical/mental health care treatment (including immunizations) and prescriptions reasonably necessary or medically advisable to maintain the life, health and well-being of my child. This includes, but is not limited to, first aid care and prevention of injuries, mental health interventions, follow-up care and the taking of over-the-counter or prescription medicines that are approved by a physician even when the child is not seen by a physician. This consent for treatment extends to the signing and conduct of: (1) legal authorization for treatment; (2) consultations; (3) anesthesia; (4) emergency examinations; (5) consent for hospitalization; (6) mental health treatment, (7) treatment or surgery that may be deemed necessary by appropriate medical personnel and (8) disclosure of all medical information, electronically, orally or in print, related to any treatment.

Participant's home address: ______________________________

City: ____________ **State:** ____________ **Zip/Postal Code:** ____________ **Country:** ____________

Home phone #: ____________ Cell #: ____________ **Email:** ____________

List any specific medical information (i.e allergic reaction to certain drugs, medications) that a physician should be aware of when treating Participant:

____

____

Parent Signature: ______________________________ **Date:** ____________

Participant Signature (If age 18 or Older): ______________________________ **Date:** ____________

INSURANCE INFORMATION: **Please provide a copy of front and back of insurance card and return it with this form.**

Please Note: Medical fees will be charged to your credit card on file, if your insurance is not accepted by the medical provider.

Insurance Company: ____________ Name of Policy Holder: ____________

Birth Date of Policy Holder: ____________ Group/Policy #: ____________ Relationship to insured: ____________

Insurance Company Address: ____________ Insurance Company Phone Number: ____________

EMERGENCY CONTACTS & CUSTODIAL INFORMATION

EMERGENCY CONTACTS (PLEASE PROVIDE TWO):

Name: ____________ Relationship to Participant: ____________

English Speaker: ☐ Yes ☐ No If no, what language? ____________ Country to be called: ____________

Home #: ____________ Cell # ____________ Email: ____________

Name: ____________ Relationship to Participant: ____________

English Speaker: ☐ Yes ☐ No If no, what language? ____________ Country to be called: ____________

Home #: ____________ Cell # ____________ Email: ____________

CUSTODIAL PARENT INFORMATION (NOT APPLICABLE IF PARTICIPANT IS AGE 18 OR OLDER):

Are the Participant's parents/guardians divorced or separated? ☐ Yes ☐ No If yes, date: ____________

Custodial Parent/Guardian: ____________ Country/State of Residence: ____________ Date of Birth ____________

Type of custody order issued: ____________ State/Country where order was issued: ____________

Note: Unless a contrary custody order is provided to IMG Academy, either parent may receive the Participant's information.

HEALTH INSURANCE REQUIREMENTS

Participant Name: ______________________ **Date of Birth:** ______________

Boarding ☐ **Non-boarding** ☐ **Male** ☐ **Female** ☐ **Sport:** ______________ **Home Country:** ______________

HEALTH INSURANCE REQUIREMENTS/MEDICAL ACCOUNT DEPOSIT

Out of concern for the health and welfare of our participants, IMG Academy ("IMGA") requires that every Academy Program participant be covered by a United States based comprehensive injury and sickness plan that will meet the high cost of medical services and is accepted by local medical providers should your child need medical attention.

Please note that this means that no international insurances, travel insurances or credit card reimbursement plans for medical expenses will be accepted for the school year as acceptable health insurance coverage by IMGA. USA based Medicaid and HMO plans not issued in the State of Florida will not be accepted by IMGA for boarding participants. This is a mandatory requirement of the registration process. Your child will not receive a permanent ID when arriving to campus until after your child provides proof of insurance coverage meeting these requirements. Without a permanent ID, your child will not be able to participate in sport and academic programs.

To meet your injury and sickness plan coverage responsibilities for your child, you may have or arrange for private US based health insurance coverage for your child. Alternatively, if you do not have US-based private health insurance coverage that meets the IMGA requirements, you can choose to enroll your child in the comprehensive injury and sickness plan described below which is offered through Clifford Allen Associates as agent for United HealthCare® Services, Inc. ("United Healthcare®") - a health care company located in Salt Lake City, Utah (the "UHC Plan"):

The UHC Plan (Primary Coverage): The UHC Plan provides you with primary, first dollar benefits for approved health care claims. The UHC Plan will cover your child during a semester or 10-month period for an annual premium (the "Premium"). The UHC Plan was designed by United Healthcare® (and not IMGA) for the participants at IMGA as stated in the enclosed brochure. Please note that the UHC Plan is offered directly by Clifford Allen Associates for United Healthcare® and not by IMGA to you. Please review the plan brochure posted on the IMG Academy website carefully for a description of the UHC Plan insurance coverage, limits and exclusions.

Medical Account Deposit: Each boarding participant is required to set up a medical account at IMGA at registration/check-in to help fund your private health insurance or UHC Plan deductibles, co-pays or fees for services not covered under your health plan. The amount to be paid into this medical account must be a minimum of $400.00. If this medical account money is not used during the year, it will be returned to you at the end of the year. **If the amount is used during the year, you agree to replace the monies necessary to fund your child's medical account with the required minimum amount.**

YOU MUST SELECT ONE OF THE TWO OPTIONS PROVIDED BELOW:

2018-2019 United Health Care Student Injury & Sickness Plan

☐ **YES*** - Enroll my child in the UHC Plan for (select one option):

International Students Only

☐ **1st Semester**	☐ **2nd Semester**	☐ **10-Month**
7/16/2018 through 12/26/2018	12/27/2018 through 6/8/2019	7/16/2018 through 6/8/2019
Premium Cost: $1,450.00*	Premium Cost: $1,450.00*	Premium Cost: $2,900.00*

Domestic Students Only

☐ **1st Semester**	☐ **2nd Semester**
7/16/2018 through 12/26/2018	12/27/2018 through 6/8/2019
Premium Cost: $1,450.00*	Premium Cost: $1,450.00*

I have reviewed a copy of the United Healthcare Student Insurance terms (available on the IMG Academy website) and understand the insurance limits and exclusions. I understand that I am financially responsible for co-pays, coinsurances or medical services not covered under this plan.

______________ Parent/Guardian Signature ______________ Printed Name ______________ Date

*If you choose to enroll your child in the UHC Plan, the Premium is due in full at the time of registration/check-in at IMGA. You may also remit payment prior to arrival by wire, designating the credit card on file, sending a check made out to IMG Academy LLC.

SELECT PAYMENT OPTION: ☐ **Wire Transfer** ☐ **Credit Card on File** ☐ **Check (Enclosed)**

☐ **NO**** - Do not enroll my child in the UHC Plan. My child is enrolled in a US based private health insurance plan that meets IMGA requirements. I understand that I am financially responsible for all deductibles, co-pays, coinsurances or medical services not covered by my plan. **<u>**If you choose this option, then you must provide an enlarged, clear copy of both sides of the insurance card evidencing your private health insurance coverage for your child.</u>** Please include the policy holder's name and policy holder's date of birth. The requirement will not be fulfilled until you provide this information and it has been accepted by IMGA.

______________ Parent/Guardian Signature ______________ Printed Name ______________ Date

______________ Insurance Policy Holder Name ______________ Policy Holder Date of Birth

If you have any questions regarding this requirement, please contact Erika Rivera at (941) 752-2616. Please complete this form and return it to the Enrollment Office by August 1 if you are applying for the Fall semester or December 1 if applying for the Spring semester. If you are choosing not to enroll your child please attach all of your insurance information as requested. You may return this information along with your enrollment packet or fax to (941) 752-2630.

IMG ACADEMY PARTICIPANT SUPPLEMENT POLICY

IMG Academy supports the use of food as the best choice for optimal sports nutrition performance. We recognize, however, that some sport supplements may be beneficial for overall health and/or performance. No supplement is a substitute for optimal nutrition, physical, and mental conditioning. Please direct all supplement questions to the Head of Nutrition at (941) 752-2648.

A. For the purposes of this policy,*"supplement"* means any product (pill, tablet, soft chew, powder, liquid, beverage, etc.) designed to augment the diet and includes one or more of the following ingredients: vitamins, minerals, herbs, botanicals, amino acids, ergogenic aids, calorie boosters, prebiotics, probiotics, concentrate, metabolite, constituent, extract, or combination of these ingredients. These products can be identified by a **"Supplement Facts"** panel. This is in contrast to a **"Nutrition Facts"** panel which is displayed on "food products".

B. For the purposes of this policy, a "Participant" means any athlete enrolled in IMG Academy school or sport and whom desires to take supplements while on IMG Academy campus.

C. Participants at IMG Academy are permitted to use supplements on the IMG Academy Permissible Supplement list with approval from parents and legal guardians. The Permissible Supplement list is available on the Current Students & Parents page on IMGAcademy.com.

Parents/legal guardians must provide the signed consent to permit the Participant to have a Permissible Supplement on campus and in their possession. Please refer to the Permissible Supplement list for those allowed to be kept in the Participant's possession (i.e. in the dorm or team locker room). Parents/legal guardians are encouraged to choose from the Permissible Supplement List.

D. Supplements on the Permissible List **must be stickered** in order to be kept in the athlete's dorm. During check-in weekend, participants may bring their supplements to the Nutrition table to be stickered. After check-in weekend, participants are responsible for bringing their Permissible Supplements to Health Services upon purchase to be stickered. This is required *every* time the product is purchased. **Supplements without a sticker that are found in the athlete's dorm or possession will be discarded.**

E. Any supplement NOT on the Permissible Supplement list requires a physician's prescription. All supplements that require a physician's prescription will be kept in Health Services and distributed to the Participant by Health Services. This assists in tracking compliance and appropriate usage. These prescriptions should come from the Participant's primary care physician. The prescription must be written in English with original, cursive signature and dated. The prescription must include the following: Type of supplement, brand and dose. All prescriptions must be renewed annually.

Each Participant is fully responsible for the supplements he or she consumes, any side effects that may occur, and any consequences that may arise from the use of the supplements, including, without limitation, loss of eligibility, or sanctions from any organization. Some supplements have been found to be contaminated, which may result in a positive drug test. Supplements on the IMG Academy Permissible List are certified to be free of banned substances from a third-party testing organization, such as NSF International, Banned Substance Control Group (BSCG), and/or Informed-Choice.

PARENT/GUARDIAN CONSENT FOR PERMITTED SUPPLEMENT USE

Participant Name: ______________________________ **Sport:** ____________________

Parent/Legal Guardian Name: ____

Parent/Guardian, please initial ONE of the following:

____ I **do not** allow my child to have **any** supplements on campus

____ I permit my child to have the following supplements on campus

Select all that apply:

□ Multivitamins
□ Vitamin C
□ Protein Powders
□ Branched Chain Amino Acids (BCAA's)
□ Creatine Monohydrate (Post Grad Athletes Only)

Parent/Guardian AND Participant, please initial:

____ (*Parent/Guardian Initials*) I am aware that any non-permissible supplements will be immediately confiscated and will be thrown away.

____ (*Participant Initials*) I am aware that any non-permissible supplements found in my possession will be immediately confiscated and discarded.

The athlete is fully responsible for what they put into their body. By signing this page and authorizing or approving the designee to utilize dietary supplement(s), I hereby take full responsibility for the use of these supplements and do not hold IMG and IMG Academy related entities, personnel and/or staff responsible for these choices. I understand the risks of taking supplements

Parent/Guardian's Signature: ______________________________ **Date:** ____________

Participant's Signature: ______________________________ **Date:** ____________

2018-2019 IMG ACADEMY PERMISSIBLE SUPPLEMENTS LIST

Protein/Muscle Performance:

Whey Protein
- BiPro Whey Protein Isolate
- BiPro Protein Water
- Klean Isolate by Klean Athlete
- Pursuit RX 100% Whey Protein
- Gatorade Recover Protein Powder (Bulk or Single Serve Packets)
- Muscle Milk (Genuine, Collegiate, & Light varieties)
- Optimum Nutrition Gold Standard 100% Whey
- Thorne Whey Protein Isolate (tub & indiv. packets)

Protein & Carbohydrate Combos
- Gatorade Recover Shakes
- EAS:Myoplex Lite
- BioSteel: Advanced Recovery Formula
- Cheribundi Tart Cherry Rebuild

Vegan Protein
- Vega Sport Performance Protein

Casein Protein
- Ascent Casein
- EAS Whey+ Casein

Soy Protein
- EAS Soy Protein
- TWINLAB Soy Protein

Branched Chain Amino Acids
- True Athlete BCAA 4:1:1
- Scivation Xtend BCAA
- Cytosport Monster Amino 6:1:1
- Thorne Amino Complex

Creatine Monohydrate (Post-Grad Athletes ONLY)[2]
- Klean Athlete Creatine Monohydrate
- MuscleMilk Cytosport Monster Creatine
- Thorne Creatine Monohydrate

Multivitamins:*

*All brands of multivitamins and vitamin care allowed on campus, however,listed are brands recommended by IMG Nutrition Coaches based on quality testing.

Teen/Youth Multivitamin
- One-A-Day Teen Advantage for Him/Her
- Animal Parade MVI (4 types) -Chewable, Liquid, GOLD, and Gummies -Whole Food Concentrates
- Nordic Naturals Nordic Berries Children's Multi-Gummies
- Thorne Basic Nutrients Multi

Men's Multivitamin
- Bayer Men's One-A-Day
- Bayer Men's One-A-Day Vitacraves (C)
- Nature Made Multi For Him
- Nature's Plus Liquilicious Source of Life
- Nature's Plus Adult Multivitamin(C)

Women's Multivitamin
- Bayer Women's One-A-Day
- Bayer Women's One-A-Day Vitacraves
- Nature Made Multi For Her
- Nature's Plus Liquilicious Source of Life
- Nature's Plus Adult Multivitamin(C)

Vitamin C
- Nature's Made Vitamin C, 500 mg (C)
- Major Vitamin C, 500 mg (C)
- Thorne Ascorbic Acid, 1000mg
- Nature's Plus Adult Multivitamin(C)

[2]Creatine Monohydrate supplementation is ONLY permissible for Post Grad athletes on campus. All other athletes will have the supplement removed from their possession. Eligible athletes should consult with Nutrition for appropriate dosage and timing recommendations.

*DISCLAIMER: Supplements are not necessary for all athletes. It is recommended to have your athlete's individual diet and nutrition needs evaluated to ensure optimal growth and performance so that no nutrients are consumed in excess or inadequate amounts.

JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

Johns Hopkins All Children's Hospital provides the health care services for the student athletes of IMG Academy. Our team is honored to oversee your child's day to day health care. The majority of the services your child requires will be provided on site at Health Services, open 24 hours per day, or at the Johns Hopkins All Children's Clinic, which is on campus. This care may include nurse visits, first aid, distribution of prescribed medications or more complex physician appointments utilizing our team of pediatricians, sports medicine specialists, and our network of pediatric sub specialists to address your child's unique medical needs.

Our staff of nurses will manage prescription and over the counter medication distribution, coordination of medical care for short-term health conditions such as infections and injuries and chronic health problems which may require scheduled specialist visits throughout the school year. They will communicate with you when such care is required, keeping you informed of your child's overall health.

The following forms are necessary for our care relationship. They include consents for treatment and for the sharing of medical information, Health Services policies and medical forms regarding your child's medical needs.

Also enclosed is a copy of the Johns Hopkins All Children's Hospital Notice of Privacy Practices, for your reference. Of course, children are always able to see their own local health care provider such as a dentist, orthodontist or chiropractor. We kindly ask that these appointments be arranged and coordinated by the family and if transportation is necessary, the family make those arrangements with IMG Transportation.

If you have any questions, please feel to contact us at 941-752-2479 or email healthservices@img.com.

Thank you,

Patrick Mularoni, M.D.
Medical Director, Sports Medicine
Johns Hopkins All Children's Hospital

Authorization to Release Medical Information to IMG Academy, LLC

Please contact Release of Information at 727-767-4048 with questions.
Completed forms can be faxed to 727-767-8312 for processing.

I hereby authorize Johns Hopkins All Children's Hospital, Inc., Pediatric Physicians Services, Inc. d/b/a All Children's Specialty Physicians, and affiliated entities and providers (collectively "JHACH") to release medical, psychological, psychiatric, developmental rehabilitative alcohol and/or drug abuse, human immunodeficiency virus (HIV) testing and treatment, ARC (AIDS related condition),and/or acquired immunodeficiency syndrome (AIDS) information to IMG Academy, LLC ("IMGA"), including IMGA staff and personnel, as needed for the following purposes: for the welfare, safety, and health of the patient; to ensure compliance and medical clearance; to further communications between IMGA staff and parent(s)/legal guardian(s) related to medical or psychological problems or form deficiencies; for operational reviews and policy recommendations related to nutrition, supplements, disease, vaccination, exposure to sun and heat, etc.; to provide education to staff and patients on health-related topics; for the development of athletic performance; and/or for the management and payment of claims, deductibles, and co-payments for patients.

Patient Name: _______________________________________ Date of Birth: __________________________

Covering periods from: _____________________________

Release to: IMG Academy, LLC ("IMGA") including all IMGA staff
5500 34th Street West
Bradenton, FL 34210

Records to be released: I agree to the release of all medical records, including if applicable and without limitation, progress notes, treatment recommendations, outpatient care clinic records, health services records, developmental rehabilitative services records, history and physicals, discharge summaries, abstracts, pathology and laboratory reports, and any other medical records related to the patient identified above.

I understand that all medical, surgical, psychiatric, and psychological information is confidential and that patient records are the property of JHACH and its related corporate entities. I will not hold JHACH, its employees, staff, or representatives responsible for any damage, mental or physical, which may be caused by the release of patient records and the information contained therein, as herein authorized.

I understand that my authorization for release may be revoked at any time by written request to JHACH, but may not be revoked to include the releases already made or actions JHACH has already taken in reliance of this authorization. Also, if this authorization is permission for JHACH to disclose information to an insurance company, in order for me to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest my coverage.

I understand that the person or organization that receives the information because of this authorization may disclose this information to other people or organizations without my knowledge or consent.

I understand I can refuse to sign this authorization and I do not need to sign this authorization to receive treatment services from JHACH.

Parent/Legal
Guardian/Patient: ____ Date: _____________ Time: ____________
(must be 18 years old to sign as Patient) Signature

Relationship to Patient: ____

JOHNS HOPKINS ALL CHILDREN'S HOSPITAL
AUTHORIZATION FOR ROUTINE DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT
(IMG Academy, LLC Use Only)

I give permission to Johns Hopkins All Children'sHospital, Inc. ("JHACH")and each of its related entities, and the physicians caring for the named patient to provide medical and, nursing care, diagnostic procedures and emergency treatment as they believe necessary or advisable in the diagnosis and treatment of the patient. I understand that imaging technology, including but not limited to videotapes, photographs of patient care, may be used during the course of treatment.

I understand that the practice of medicine isnotanexactscience and that diagnosis and treatment may involve risks or injury, or even death. I understand that no guarantee or promise has been made to ensure treatment results.

I understand that many physicians, physician assistants, nurse practitioners, and other health care professionals may be involved in providing care and may not be directly employed by JHACH. I also understand that JHACH may delegate or refer health care duties or responsibilities to independent physicians, physician's assistants, therapists, nurse practitioners or other health care professionals. I agree that when JHACH delegates these health care duties and responsibilities to independent persons, JHACH is not responsible for the conduct of such persons; and I discharge JHACH from any duty to provide the delegated care. Further, I realize that these caregivers may be training others who may be present during care as part of their education.

I understand that any information regarding me/my child's evaluation and treatment may be gathered for research and/or teaching purposes.

https://www.hopkinsallchildrens.org/about-us/important-notices/notice-of-privacy-practices

_________ I have been provided with the Johns Hopkins All Children's Hospital Notice of Privacy Practices.
(Initial here)

This form has been fully explained to me, and I am satisfied that I understand this consent and have signed in the capacity indicated below.

- ☐ As an adult.
- ☐ As a parent consenting for his or her minor child.
- ☐ As a legal guardian consenting for his or her ward.
- ☐ As an adult, in the absence of a parent, consenting for the patient (parental permission on file). As
- ☐ a person,in the absence of a parent, having power of attorney covering consent for his patient (parental permission on file).
- ☐ As foster parent consenting for routine medical or emergency room treatment (foster care placement letter on file).

____
(Print Patient Name)

____
(Adult Patient or Parent/Guardian Signature) (Date) (Time)

____
(Print Name) (Relationship)

JOHNS HOPKINS ALL CHILDREN'S HOSPITAL, INC.
FINANCIAL AGREEMENT
(For IMG Academy LLC use only)

Patient/Participant Name: ______________________

Policyholder Name: ______________________

Policyholder's Relationship to Patient/Participant: __________

I. HMO/PPO/INSURANCE STATEMENT: As policyholder, I agree that if the patient/participant is covered by any insurance company, Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or other third party payer, I shall inform Johns Hopkins All Children's Hospital, Inc. ("JHACH") and/or any physician group rendering services, of such information and shall provide them with the appropriate identification card prior to or upon rendering of treatment by JHACH on the IMGA campus.

I agree to pay for any and all charges not covered or fully covered by the insurance, HMO, PPO, or third party payer, which covers the patient/participant, including but not limited to co-payments, deductible, out of plan services rendered by a nonparticipating provider and non-covered services regardless of whether determination of non-coverage is justified or mistaken.

I agree to pay for the total charges (balance in full) if admission/service is denied by my insurance, HMO, PPO or other payer for any reason whether such denial is justified or mistaken.

I also agree that, regardless of any collection action, the responsibility to perform any and all other actions necessary to obtain payment from any insurer, HMO, PPO, or other payer shall remain at all times with the policyholder as provided in such policy.

II. RELEASE OF MEDICAL INFORMATION: I hereby authorize Johns Hopkins All Children's Hospital, Inc. and each of its related entities, and any physician group rendering services, including Pediatric Physicians Services, Inc. (PPS) or, All Children's Specialty Services ("ACSP"), to disclose all or any part of the patient's/participant's record to any person or corporation for purposes of payment or health care operations. This means that information from the patient's/participant's medical record may be furnished as necessary to process claims, obtain reimbursement or payment, for all or part of the charges from an insurer, HMO, PPO, ERISA plan, employer, or other third party payer.

III. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize, assign and direct any and all third parties to pay benefits, including insurance benefits otherwise payable with respect to the patient/participant, to the hospital or any physician group rendering services, such as PPS or ACSP. This irrevocable assignment to the hospital or physician group shall apply to all benefits under any policy of insurance, indemnity agreement, or any other collateral source for any service provided to the patient/participant. It is my express desire that Johns Hopkins All Children's Hospital, Inc. and the treating physicians be paid before any benefits are paid to me, the patient/participant, or my attorney. I understand that I am fully responsible for any balance not paid by the insurers or other payers, and I agree to pay any outstanding balance including co-payments, and deductible amounts. If the patient/participant's account has to be referred to a collection agency, I will pay all costs of the collection, including reasonable attorney's fees. I agree that the assignment of insurance monies does not alter my obligation to pay, and I understand that the filing of claim for payment with an insurance carrier or other third-party payer is not equivalent to payment, but only an accommodation for my benefit.

IV. GUARANTEE OF PAYMENT: I agree to pay for all charges for services ordered on behalf of the patient/participant, by physicians attending the patient/participant, and agree to pay all charges at the time of service or upon receipt of statement. I understand that I am responsible for any costs incurred in the collection of the patient's/participant's account(s) in case of default, including reasonable attorney fees and/or court costs.

I understand that some of the physicians, physician assistants, or associates caring for the patient/participant may not necessarily be agents, servants or employees of Johns Hopkins All Children's Hospital, Inc., but are independent contractors. Further, I realize that I am additionally responsible for charges for physician and ancillary services ordered on behalf of the patient/participant and I understand that these charges may be billed separately from Johns Hopkins All Children's Hospital's charges.

V. STATEMENT OF TRUTHFULNESS: I state that any and all of the information provided to Johns Hopkins All Children's Hospital, Inc., and other treating physicians concerning any financial information, insurance information and any information concerning coverage under any type of health plan is true and correct. I further understand and acknowledge that if any of the information I provide Johns Hopkins All Children's Hospital, Inc., or the physicians is in any way incorrect or untrue, then I may be liable for damages and penalties for violating this agreement and Florida law, including but not limited to Florida Statute § 817.50 which prohibits a person from fraudulently obtaining service from a hospital.

______________________ ______________

Signature of Policyholder Date

______________________ ______________

Signature of Guarantor/Relationship to Patient/Participant (If other than policyholder) Date

EL2

Revised 03/16

Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 1 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2. **This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.**

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	

	Yes	No
36. Do you want to weigh more or less than you do now?	____	____
37. Do you lose weight regularly to meet weight requirements for your sport?	____	____
38. Do you feel stressed out?	____	____
39. 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: ____/ ____/ ____

Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 2 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2. **This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.**

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: ______________________

Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 3 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2. **This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.**

Student's Name: ____

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation

____ Disability: ____ Diagnosis: ____

____

____ Precautions: ____

____

____ Not cleared for: ____ Reason: ___________________________________

____ Cleared after completing evaluation/rehabilitation for: ____

Recommendations: ____

Name of Physician (print): ____ Date: ____/____/_______

Address: ____

Signature of Physician: ____

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.

Florida High School Athletic Association

Revised 03/18

Consent and Release from Liability Certificate (Page 1 of 4)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the most recent signature.
This form is non-transferable; a change of schools during the validity period of this form will require this form to be re-submitted.

School: ____ **School District (if applicable):** ___________________________

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

I have read the (condensed) FHSAA Eligibility Rules printed on Page 4 of this "Consent and Release Certificate" and know of no reason why I am not eligible to represent my school in interscholastic athletic competition. If accepted as a representative, I agree to follow the rules of my school and FHSAA and to abide by their decisions. I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury, including the potential for a concussion, and even death, is possible in such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved. Should I be 18 years of age or older, or should I be emancipated from my parent(s)/guardian(s), I hereby release and hold harmless my school, the schools against which it competes, the school district, the contest officials and FHSAA of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against FHSAA because of any accident or mishap involving my athletic participation. I hereby authorize the use or disclosure of my individually identifiable health information should treatment for illness or injury become necessary. I hereby grant to FHSAA the right to review all records relevant to my athletic eligibility including, but not limited to, my records relating to enrollment and attendance, academic standing, age, discipline, finances, residence and physical fitness. I hereby grant the released parties the right to photograph and/or videotape me and further to use my name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein. I understand that the authorizations and rights granted herein are voluntary and that I may revoke any or all of them at any time by submitting said revocation in writing to my school. By doing so, however, I understand that I will no longer be eligible for participation in interscholastic athletics.

Part 2. Parental/Guardian Consent, Acknowledgement and Release (to be completed and signed by a parent(s)/guardian(s) at the bottom; where divorced or separated, parent/guardian with legal custody must sign.)

A. I hereby give consent for my child/ward to participate in any FHSAA recognized or sanctioned sport **EXCEPT** for the following sport(s):

____

List sport(s) exceptions here

B. I understand that participation may necessitate an early dismissal from classes.

C. I know of, and acknowledge that my child/ward knows of, the risks involved in interscholastic athletic participation, understand that serious injury, and even death, is possible in such participation and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. With full understanding of the risks involved, I release and hold harmless my child's/ward's school, the schools against which it competes, the school district, the contest officials and FHSAA of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against the FHSAA because of any accident or mishap involving the athletic participation of my child/ward. I authorize emergency medical treatment for my child/ward should the need arise for such treatment while my child/ward is under the supervision of the school. I further hereby authorize the use or disclosure of my child's/ward's individually identifiable health information should treatment for illness or injury become necessary. I consent to the disclosure to the FHSAA, upon its request, of all records relevant to my child/ward's athletic eligibility including, but not limited to, records relating to enrollment and attendance, academic standing, age, discipline, finances, residence and physical fitness. I grant the released parties the right to photograph and/or videotape my child/ward and further to use said child's/ward's name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein.

D. I am aware of the potential danger of concussions and/or head and neck injuries in interscholastic athletics. I also have knowledge about the risk of continuing to participate once such an injury is sustained without proper medical clearance.

READ THIS FORM COMPLETELY AND CAREFULLY. YOU ARE AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA USES REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH, TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

E. ~~**I agree that in the event we/I pursue litigation seeking injunctive relief or other legal action impacting my child (individually) or my child's team participa-tion in FHSAA state series contests, such action shall be filed in the Alachua County, Florida, Circuit Court.**~~

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

G. Please check the appropriate box(es):

____ My child/ward is covered under our family health insurance plan, which has limits of not less than $25,000.

Company: ____________________________________ **Policy Number:** ______________________

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

____ I have purchased supplemental football insurance through my child's/ward's school.

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE (Only one parent/guardian signature is required)

Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date ___/___/___
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date ___/___/___

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE (student must sign)

Name of Student (printed)	Signature of Student	Date ___/___/___

Florida High School Athletic Association

Consent and Release from Liability Certificate for Concussions (Page 2 of 4)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the most recent signature.

School: ______________________________ **School District** (if applicable)**:** ______________________

Concussion Information

Concussion is a brain injury. Concussions, as well as all other head injuries, are serious. They can be caused by a bump, a twist of the head, sudden deceleration or acceleration, a blow or jolt to the head, or by a blow to another part of the body with force transmitted to the head. You can't see a concussion, and more than 90% of all concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. All concussions are potentially serious and, if not managed properly, may result in complications including brain damage and, in rare cases, even death. Even a "ding" or a bump on the head can be serious. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, your child should be immediately removed from play, evaluated by a medical professional and cleared by a medical doctor.

Signs and Symptoms of a Concussion:

Concussion symptoms may appear immediately after the injury or can take several days to appear. Studies have shown that it takes on average 10-14 days or longer for symptoms to resolve and, in rare cases or if the athlete has sustained multiple concussions, the symptoms can be prolonged. Signs and symptoms of concussion can include: (not all-inclusive)

- Vacant stare or seeing stars
- Lack of awareness of surroundings
- Emotions out of proportion to circumstances (inappropriate crying or anger)
- Headache or persistent headache, nausea, vomiting
- Altered vision
- Sensitivity to light or noise
- Delayed verbal and motor responses
- Disorientation, slurred or incoherent speech
- Dizziness, including light-headedness, vertigo(spinning) or loss of equilibrium (being off balance or swimming sensation)
- Decreased coordination, reaction time
- Confusion and inability to focus attention
- Memory loss
- Sudden change in academic performance or drop in grades
- Irritability, depression, anxiety, sleep disturbances, easy fatigability
- In rare cases, loss of consciousness

DANGERS if your child continues to play with a concussion or returns too soon:

Athletes with signs and symptoms of concussion should be removed from activity (play or practice) immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to sustaining another concussion. Athletes who sustain a second concussion before the symptoms of the first concussion have resolved and the brain has had a chance to heal are at risk for prolonged concussion symptoms, permanent disability and even death (called "Second Impact Syndrome" where the brain swells uncontrollably). There is also evidence that multiple concussions can lead to long-term symptoms, including early dementia.

Steps to take if you suspect your child has suffered a concussion:

Any athlete suspected of suffering a concussion should be removed from the activity immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without written medical clearance from an appropriate health-care professional (AHCP). In Florida, an appropriate health-care professional (AHCP) is defined as either a licensed physician (MD, as per Chapter 458, Florida Statutes), a licensed osteopathic physician (DO, as per Chapter 459, Florida Statutes). Close observation of the athlete should continue for several hours. You should also seek medical care and inform your child's coach if you think that your child may have a concussion. Remember, it's better to miss one game than to have your life changed forever. When in doubt, sit them out.

Return to play or practice:

Following physician evaluation, the ***return to activity process*** requires the athlete to be completely symptom free, after which time they would complete a step-wise protocol under the supervision of a licensed athletic trainer, coach or medical professional and then, receive written medical clearance of an AHCP.

For current and up-to-date information on concussions, visit http://www.cdc.gov/concussioninyouthsports/ or http://www.seeingstarsfoundation.org

Statement of Student Athlete Responsibility

Parents and students should be aware of preliminary evidence that suggests repeat concussions, and even hits that do not cause a symptomatic concussion, may lead to abnormal brain changes which can only be seen on autopsy (known as Chronic Traumatic Encephalopathy (CTE)). There have been case reports suggesting the development of Parkinson's-like symptoms, Amyotropic Lateral Sclerosis (ALS), severe traumatic brain injury, depression, and long term memory issues that may be related to concussion history. Further research on this topic is needed before any conclusions can be drawn.

I acknowledge the annual requirement for my child/ward to view "Concussion in Sports-What You Need to Know" at www.nfhslearn.com. I accept responsibility for reporting all injuries and illnesses to my parents, team doctor, athletic trainer, or coaches associated with my sport including any signs and symptoms of CONCUSSION. I have read and understand the above information on concussion. I will inform the supervising coach, athletic trainer or team physician immediately if I experience any of these symptoms or witness a teammate with these symptoms. Furthermore, I have been advised of the dangers of participation for myself and that of my child/ward.

______________________	______________________	____/____/______
Name of Student-Athlete (printed)	Signature of Student-Athlete	Date
______________________	______________________	____/____/______
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date
______________________	______________________	____/____/______
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date

EL3

Florida High School Athletic Association

Revised 03/18

Consent and Release from Liability Certificate for Sudden Cardiac Arrest and Heat-Related Illness (Page 3 of 4)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the most recent signature.

School: ____ **School District** **(if applicable)**: ___________________________

Sudden Cardiac Arrest Information

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

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

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

It is strongly recommended all coaches, whether paid or volunteer, are regularly trained in CPR and the use of an AED. Training is encouraged through agencies that provide hands-on training and offer certificates that include an expiration date.

Automatic external defibrillators (AEDs) are required at all FHSAA State Series games, tournaments and meets. The FHSAA also strongly recommends that they be available at all preseason and regular season events as well along with coaches/individuals trained in CPR.

What to do if your student-athlete collapses:

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

FHSAA Heat-Related Illnesses Information

People suffer heat-related illness when their bodies cannot properly cool themselves by sweating. Sweating is the body's natural air conditioning, but when a person's body temperature rises rapidly, sweating just isn't enough. Heat-related illnesses can be serious and life threatening. Very high body temperatures may damage the brain or other vital organs, and can cause disability and even death. Heat-related illnesses and deaths are preventable.

Heat Stroke is the most serious heat-related illness. It happens when the body's temperature rises quickly and the body cannot cool down. Heat Stroke can cause permanent disability and death.

Heat Exhaustion is a milder type of heat-related illness. It usually develops after a number of days in high temperature weather and not drinking enough fluids.

Heat Cramps usually affect people who sweat a lot during demanding activity. Sweating reduces the body's salt and moisture and can cause painful cramps, usually in the abdomen, arms, or legs. Heat cramps may also be a symptom of heat exhaustion.

Who's at Risk?

Those at highest risk include the elderly, the very young, people with mental illness and people with chronic diseases. However, even young and healthy individuals can succumb to heat if they participate in demanding physical activities during hot weather. Other conditions that can increase your risk for heat-related illness include obesity, fever, dehydration, poor circulation, sunburn, and prescription drug or alcohol use.

By signing this agreement, the undersigned acknowledges that the information on Sudden Cardiac Arrest and Heat-Related Illness have been read and understood. I acknowledge optional educational opportunities in cardiac arrest at www.nfhslearn.org. Please go to www.fhsaa.org/departments/health for further instructions to view the courses. I have been advised of the dangers of participation for myself and that of my child/ward.

Name of Student-Athlete (printed)	Signature of Student-Athlete	Date ___/___/___
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date ___/___/___
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date ___/___/___

Florida High School Athletic Association

Revised 03/18

Consent and Release from Liability Certificate (Page 4 of 4)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the most recent signature.

Attention Student and Parent(s)/Guardian(s)

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

1. **This form is non-transferable**; a separate form must be completed for each different school at which a student participates.
2. Must be regularly enrolled and in regular attendance at your school. **If the student is a home education student or attends a charter school or Florida Virtual School - Full time Program or a special/alternative school or certain small non-member private schools, the student must declare in writing his/her intention to participate in athletics to the school at which the student is permitted to participate.** Home education students and students attending small non-member private schools must be approved through the use of a separate form prior to any participation. (FHSAA Bylaw 9.2, Policy 16 and Administrative Procedure 1.8)
3. Must attend school within 10 days of the beginning of **each semester** to be eligible during **that semester**. (FHSAA Bylaw 9.2)
4. Must maintain at least a cumulative 2.0 grade point average on a 4.0 unweighted scale prior to the semester in which the student wishes to participate. This GPA must include all courses taken since the student entered high school. A sixth, seventh or eighth grade student must have earned at least a 2.0 grade point average on 4.0 unweighted scale the previous semester. (FHSAA Bylaw 9.4)
5. Must not have graduated from any high school or its equivalent. (FHSAA Bylaw 9.4)
6. Must not have **enrolled in the ninth grade for the first time** more than four school years ago. If the student is a sixth, seventh or eighth grade student, the student must not participate if repeating that grade. (FHSAA Bylaw 9.5)
7. Must have signed permission to participate from the student's parent(s)/legal guardian(s) on a form (EL3) provided the school. (Bylaw 9.8)
8. Must not turn 19 before September 1st to participate at the high school level; must not turn 16 prior to September 1st to participate at the junior high level; and must not turn 15 prior to September 1st to participate at the middle school level, otherwise the student becomes permanently ineligibile. (FHSAA Bylaw 9.6)
9. Must undergo a pre-participation physical evaluation and be certified as being physically fit for participation in interscholastic athletics (form EL2).
10. Must be an amateur. This means the student must not accept money, gift or donation for participating in a sport, or use a name other than his/her own when participating. (FHSAA Bylaw 9.9)
11. Must not participate in an all-star contest in a sport prior to completing his/her high school eligibility in that sport. (FHSAA Policy 26)
12. Must display good sportsmanship and follow the rules of competition **before, during and after** every contest in which the student participates. If not, the student may be suspended from participation for a period of time. (FHSAA Bylaw 7.1)
13. Must not provide false information to his/her school or to the FHSAA to gain eligibility. (FHSAA Bylaw 9.1)
14. Youth exchange, other international and immigrant students must be approved by the FHSAA office prior to any participation. Exceptions may apply. See your school's principal/athletic director. (FHSAA Policy 17)
15. Must refrain from hazing/bullying while a member of an athletic team or while participating in any athletic activities sponsored by or affiliated with a member school.

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

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

______________________	______________________	____/____/______
Name of Student-Athlete (printed)	Signature of Student-Athlete	Date
______________________	______________________	____/____/______
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date
______________________	______________________	____/____/______
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date