St. Mark's
EPISCOPAL CHURCH AND SCHOOL

Dear Parents:

We know that getting ready for a new school year can be both exciting and hectic. Below is an explanation of Health Care forms required by the School Clinic before the start of school. Hopefully, this letter will help you get a "jump start."

All students for the 2017-2018 school year are required to have:

- **Family Emergency Information Form** on file in the clinic prior to the first day of school. A new form is required every new school year.

- **Authorization for Medication/Treatment Form** which must be signed by a Physician or Health Practitioner licensed to practice in the State of Florida in order to dispense any medication to your child, including over the counter medication. A new form is required every new school year.

All new students, Early Childhood, Pre-K and Kindergarten students must submit the following additional health documents:

- Copy of **Birth Certificate** OR copy of **Passport** (**New Students Only**)

- **Current Physical Examination Form** (DH3040):
  This form is supplied by your physician or health care provider. The physical exam must be dated within 12 months of the first day of school. A parent must complete and sign Part One of this form**.** Photocopies are acceptable.

- **Florida Certificate of Immunizations Form** (DH680):
  This form is provided by your physician with documentation for the following immunizations:

  Immunizations Required for Early Childhood/Preschool

  - Diphtheria-Tetanus-Pertussis Series
  - Haemophilus influenzae type b (Hib)
  - Hepatitis B Series
  - Measles-Mumps-Rubella (MMR)
  - Polio Series
  - Varicella
  - Pneumococcal Conjugate(**EC only)**

Over please

Immunizations Required for Kindergarten – 8th Grade

- Diphtheria-Tetanus-Pertussis Series
- Hepatitis B Series
- Measles-Mumps-Rubella (MMR 2x)
- Polio Series
- Varicella - **2 doses required for Kindergarten thru Grade 8**

Immunizations Required for 7th Grade Entry:

- Tetanus-Diphtheria Booster (Tdap)

These forms are required according to Florida Law! We will be unable to allow your child to attend class without these documents.

EC and PK students will also receive an **Influenza Virus Acknowledgement Form** from the teacher or nurse at Orientation. This form will also need to be completed and returned to the Clinic.

For additional help we have provided a "Clinic Checklist."
If you have any questions, please do not hesitate to contact the clinic at 954-563-4508 or email us at clinic@saintmarks.com.

We hope you have a wonderful summer and that this information is helpful to you in avoiding any disappointment at the beginning of the school year.

Sincerely,

Jami Kadivar RN and Grace Serro RN

Over please

St. Mark's Episcopal School
2017 - 2018 Clinic Forms Checklist

Please use this checklist as a personal reference for all required forms for the 2017 – 2018 school year.

New students (See grade level for specific documentation)

___ Family Emergency Form

__ Medication Form – Requires a doctor's signature
(Over the counter medication may not be administered to your child without a doctor's signature per Florida Law)

____ Florida certificate of Immunization – **DH680** (all immunizations must be documented)

____ State of Florida physical exam – **DH3040** (dated on or before August 16, 2017)

____ Birth Certificate or Passport (copy accepted)

PK1-Kindergarten

____ Family Emergency Form

____ Medication Form – Requires a doctor's signature
(Over the counter medication may not be administered to your child without a doctor's signature per Florida Law)

____ Current Florida Certificate of Immunization (**DH680**).
***Kindergartners** must have 2 doses of the Varicella vaccine before starting school and it must be documented on this form.

____ State of Florida physical exam – **DH3040**

1st-4th grades

____ Family Emergency Form

____ Medication Form – Requires a doctor's signature (Over the counter medication may not be administered to your child without a doctor's signature per Florida Law)

____ Current Florida Certificate of Immunization (**DH680**)

____State of Florida physical exam – **DH3040**

5th-8th grades

____ Family Emergency Form

____ Medication Form – Requires a doctor's signature (Over the counter medication cannot be administered to your child without a doctor's signature per Florida Law)

____ Current Florida Certificate of Immunization (**DH680**) ***7th grade**rs must have the Tetanus booster vaccine before starting school and it must be documented on this form.

____State of Florida physical exam – **DH3040**

____ FHSAA Forms; EL2, EL3
(All students playing a team sport during the 2017-2018 school year.Forms available at https://www.fhsaa.org)

Please PRINT in BLACK INK
*Please complete **ONE** form per family*

Office Use Only

Date _____

R.N. _____

St. Mark's
EPISCOPAL CHURCH AND SCHOOL

Family Emergency Information

Student's Name _____ M/F _____ Grade _____ DOB _____

Student's Name _____ M/F _____ Grade _____ DOB _____

Student's Name _____ M/F _____ Grade _____ DOB _____

Family Address _____ City _____

State _____ Zip _____ Home Phone # _____

Mother's Name _____

Home Address _____

Home Phone _____ Cell Phone _____ Email _____

Business Name _____ Position _____ Phone # _____

Father's Name _____

Home Address _____

Home Phone _____ Cell Phone _____ Email _____

Business Name _____ Position _____ Phone # _____

Student's Physcian _____ Phone # _____

Student's Name	Health Concern/Allergy	Symptoms	What should be done?

This information will be released to St. Mark's faculty and staff as needed. No medication, including over-the-counter medications, will be given by clinic personnel unless a St. Mark's Medication/Treatment form ***signed by <u>both</u> the physician and parent*** is on file in the clinic. Any medication given must be listed on the form.

IN CASE OF EMERGENCY, in whose care may we release the child if parent(s) cannot be located?

Name	Home Phone	Business Phone	Cell Phone

Person(s) **not** permitted to remove child: _____

Emergency Release Form

In the event a medical emergency arises during the time that a child is under the supervision of the staff of St. Mark's Episcopal School, every attempt will be made to contact the parent/guardian of the child or other authorized person immediately. In the event that a prent/guardian or other authorized person cannot be located, the form below will serve as authorization for a member of the St. Mark's Episcopal School staff to seek the necessary medical attention for the child.

I, _____, hereby authorize a St. Mark's Episcopal staff member to authorize medical care for _____, and/or _____, should the need arise, under the supervision of a physician licensed to practice medicine in the State of Florida.

Parent/Guardian Signature _____ **Date** _____

Three easy ways to return this form:

(1) Fax to 954-563-0504, Attention: Main School Office

(2) Deliver the form to St. Mark's Episcopal School Main Office

(3) Mail the form to: St. Mark's Episcopal School at 1750 East Oakland Park Boulevard, Fort Lauderdale, FL 33334

St. Mark's
EPISCOPAL CHURCH AND SCHOOL

NOTE:
This form requires a physician's signature.

AUTHORIZATION FOR MEDICATION/TREATMENT

Student's Name _____ Today's Date _____

Grade _____ Birth Date _____ Best Contact# _____

Allergies _____

Diagnosis _____

Mother's Insurance Carrier _____ Social Security # _____

Father's Insurance Carrier _____ Social Security # _____

MEDICATION DURING SCHOOL HOURS AND SCHOOL TRIPS

MEDICATION	CHECK ONE: Yes	No	DOSAGE & ROUTE	FREQUENCY	SPECIFIC TIMES	SPECIAL INSTRUCTIONS/SIDE EFFECTS
Tylenol			p.o.			
Advil			p.o.			
Benadryl			p.o.			
Cough Syrup			p.o.			
Antacid			p.o.			
Anti-itch cream			topical			
Antibiotic ointment			topical			

TREATMENTS DURING SCHOOL HOURS AND SCHOOL TRIPS

PROCEDURE	TYPE	MEDICATION AMOUNT	FREQUENCY / SPECIFIC TIMES
Inhaler Treatment			
Nebulizer Treatment			
Blood Glucose Check			
EpiPen			

Any of the above procedures required for emergency care? Yes ____ No ____

If yes, please specify: _____

_____

_____

_____

*— Please complete **both sides** of this form. —*

AUTHORIZATION FOR MEDICATION/TREATMENT

(continued)

List any limitations/precautionary measures that should be considered (*e.g. physical education, outdoor activities, transporting, lifting, moving, special devises or equipment*):

_____

_____

_____

List any emergency precautions/health emergencies that should be anticipated for this student (*e.g. allergy triggers, diabetic reactions, etc.*):

_____

_____

_____

_____ _____

Physician's Name ***(Print)*** Physician's Signature ***(Mandatory)***

_____ _____

Physician's Phone Physician's Fax

Physician's Office Address _____ Date Completed: _____

PARENTAL PERMISSION FOR MEDICATIONS/TREATMENT

(To be completed by the student's Parent/Guardian)

I grant the nurse, principal, or his/her designee the permission to assist or perform the administration of each medication or treatment/procedure to or for my child as instructed by my child's physician at school or duing school-related events. I hereby release the School and its employees from injury, loss, or damage resulting from the school's proper adiministration of medications or the treatment/procedures as prescribed by my child's physician as referenced in this authorization from or in seperate prescription documents.

NOTE:

- Medications must be supplied in the original container (both over-the-counter and prescription). Ask the pharmacist to divide prescription medication into two completely labeled containers, providing one for home and one for school.
- Only medications/treatments authorized by a physician may be administered by school personnel.
- It is your responsibility to notify the school when there is a change in medication/treatment regimen.

_____ _____

Parent/Guardian Name ***(Print)*** Signature of Parent/Guardian

Date Signed: _____ Home Phone: _____

Cell Phone: _____ Work Phone: ***(include extension)*** _____

Other numbers where you may be reached during school hours: _____

_____

_____

*— Please complete **both sides** of this form. —*

Three easy ways to return this form:

(1) Fax to 954-563-0504, Attention: Main School Office

(2) Deliver the form to St. Mark's Episcopal School Main Office

(3) Mail the form to: St. Mark's Episcopal School at 1750 East Oakland Park Boulevard, Fort Lauderdale, FL 33334

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	

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

Revised 03/16

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.

EL3

Florida High School Athletic Association

Revised 04/16

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: St. Mark's Episcopal 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 identifable 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 identifable 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 participation 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: St. Mark's Episcopal 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
		_____/_____/_____

Revised 04/16

Florida High School Athletic Association

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: St. Mark's Episcopal 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

Florida High School Athletic Association

Revised 04/16

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 be less than 19 years 9 months old to participate in high school; 16 years 9 months old to participate in junior high school; and 15 years 9 months old to participate in middle school, otherwise the student becomes ineligible to participate at that level. Students entering 9th grade in 2014-15 and thereafter must not turn 19 before September 1st, otherwise the student becomes ineligible to participate. (FHSAA Bylaw 9.6)
9. Must undergo a pre-participation physical evaluation and be certified as being physically fit for participation in interscholastic athletics (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
		_____/_____/_____