

STUDENT-ATHLETES MUST TURN IN THIS SPORTS PACKET AT LEASE 24 HOURS PRIOR TO TRY-OUTS. STUDENT - ATHLETES TURNING IN PACKETS ON THE FIRST DAY OF TRY-OUTS, MAY NOT BE ABLE TO PARTICIPATE UNTIL SECOND DAY OF TRY-OUTS.

OKALOOSA COUNTY SCHOOL DISTRICT
STUDENT SERVICES/RISK MANAGEMENT

MIS 5342
REV.1/2014

**INTERSCHOLASTIC ATHLETICS PARENTAL PERMISSION, RELEASE
EMERGENCY MEDICAL AUTHORIZATION AND AUTHORIZATION TO RELEASE INFORMATION**

NOTICE TO THE MINOR CHILD'S NATURAL GUARDIAN

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 OKALOOSA COUNTY SCHOOL DISTRICT, ITS SCHOOL BOARD, ITS EMPLOYEES, AGENTS OR ASSIGNS 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 CAN NOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM, YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM OKALOOSA COUNTY SCHOOL DISTRICT, ITS SCHOOL BOARD, ITS EMPLOYEES, AGENTS OR ASSIGNS 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 OKALOOSA COUNTY SCHOOL DISTRICT, ITS EMPLOYEES, AGENTS OR ASSIGNS HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

No student will be allowed to practice or participate in any organized interscholastic athletic activity until this document is signed notarized and returned to the school Athletic Department

Student name _____ Grade _____ male / female

Address _____ Home phone _____

City _____ Zip _____ Emergency phone _____

PURPOSE: To provide the consent of parents and/or guardians for students to participate in interscholastic activities of the School District and provide a hold harmless release of liability, to authorize the provision of emergency medical treatment for that student who may become ill or injured during such activities and authorizing the release of protected health information.

PLEASE COMPLETE ALL PARTS

PART I – PARENTAL /GUARDIAN PERMISSION, ACKNOWLEDGEMENT AND RELEASE

A. I, _____ hereby grant permission for _____ (the "Student Athlete") to participate at **PRYOR MIDDLE School** during the school year, and 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, and the Okaloosa County School District, its School Board, its officers, employees, agents or assigns, 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 Okaloosa County School District, its School Board, its officers, employees, agents or assigns, because of any accident or mishap involving the athletic participation of my child/ward.

I understand the Okaloosa County Middle School Athletic Conference requires all students participating in interscholastic athletics be covered by a medical insurance policy providing a minimum of \$25,000 limit for medical expenses. I hereby certify _____ is covered by medical insurance providing at least \$25,000 for medical expenses. **The name of our medical insurance company is _____ which will cover this child in the event of an injury.** I assume full responsibility and liability for any and all expenses connected with an injury and/or illness that is not paid by out insurance company or through Military benefits if this child is entitled to military privileges. I further certify I will notify the principal of the school this child is attending if there is any change in this insurance coverage, and I will purchase the Student and/or Football insurance offered at the school. (STUDENT AND/OR FOOTBALL INSURANCE MAY BE PURCHASED AT YOUR SCHOOL)

B. 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.

C. I also hereby grant permission for my child/ward to be transported by private automobile and/or School District authorized transportation during the school year in which this release is effective to and from all interscholastic sports events.

PART II – EMERGENCY MEDICAL AUTHORIZATION

In the event reasonable attempts me at _____ (phone number) have been unsuccessful, I give my consent for (1) the administration of any treatment deemed necessary by _____ (preferred physician) or _____ (preferred dentist), or in the event the designated preferred practitioner is not available, by another physician or dentist and (2) the transfer and admission of the child to _____ (preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist concurring in the necessity for such surgery are obtained prior to the performance of such surgery. I hereby authorize any treating physicians, including athletic trainers and team volunteer doctors, to provide information to school officials regarding my child's medical condition or injuries. **Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted. (list or write "none")** _____

MEDICAL PROVIDERS MAY ACCEPT A PHOTOCOPY OF THIS SIGNED AUTHORIZATION AS IF IT WERE AN ORIGINAL FOR ALL PURPOSES.

PART III – AUTHORIZATION/CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the athletic trainers, sports medicine staff and other health care personnel representing _____ (student) To release information regarding the Student Athlete's protected health information and related information regarding injury or illness during the Student Athlete's training for and participation in interscholastic sports at **PRYOR MIDDLE SCHOOL**. This protected health information may concern the Student Athlete's medical status, medical conditions, injuries, prognosis, diagnosis, athlete's participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, hospitals and/or medical clinics and laboratories, Student Athlete's coaches, medical insurance coordinators, the school's Athletic Director and Principal, athletic and/or school administrators, chaplains and/or clergy members, and officials of the Okaloosa County Middle School Athletic Conference. I also authorize the Student Athlete's coaches and other school staff to release protected health information to the athletic trainer, sports medicine staff and other health care personnel as identified above and to other health care professionals providing services to the Student Athlete. As the parent or guardian of the Student Athlete, I hereby confirm that I have signed this authorization/consent for the disclosure of the Student Athlete's protected health information voluntarily. I understand that my child's protected health information is protected by federal regulations under the Health Information Portability and Accountability Act (HIPAA) of the Family Educational Rights and privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment I the parent/legal guardian understand that once protected health information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization/consent any time by notifying in writing to the school's Athletic Director, but if I do, it will not have any effect on the actions the Okaloosa county School officials took in reliance on this authorization/consent prior to receiving the revocation. I understand that I may see and obtain a copy of all protected health information described on this form, for a reasonable copy fee, if I ask for it. I further understand that I may request a copy of this form after I sign it. This authorization/consent expires one year from the date it is signed.

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE AND RELEASE OF THE STUDENT ATHLETE'S PROTECTED HEALTH INFORMATION AS STATED.

Concussion & Heat Related Illness Information Release Form must be signed along with this form, PRIOR TO NOTARIZATION, and the terms and conditions of the EL3CH Form are considered incorporated into this Authorization.

BY SIGNING BELOW I VERIFY THAT I HAVE READ, REVIEWED AND COMPLETED ALL THREE (3) PARTS OF THIS PERMISSION AND AUTHORIZATION FROM AND KNOW IT CONTAINS A RELEASE.

Date Printed Name of Parent or Guardian Signature of Parent or Guardian

STATE OF FLORIDA-COUNTY OF OKALOOSA

The foregoing instrument was acknowledge before me this _____ by _____
Date Name of Person Acknowledged

Who is personally known to me or who has produced _____ as identification and who did/did not take an oath
Type of Identification

Signature of Notary Taking Acknowledgement Name of Notary (Typed, Printed or Stamped)
Notary Expiration: _____

OKALOOSA COUNTY SCHOOL DISTRICT/STUDENT INTERVENTION SERVICES
MIDDLE SCHOOL ATHLETIC CONFERENCE PRE-PARTICIPATION PHYSICAL EVALUATION

PAGE 1 OF 3

This completed form must be kept on file at the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2.

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: _____ City: _____ Zip: _____ 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.

- | | | | | | | |
|---|----------|--|---------------|-----------|-----------|---------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | Yes / No | 26. Have you ever become ill from exercising in the heat? | Yes/No | | | |
| 2. Do you have an ongoing chronic illness? | Yes/No | 27. Do you have a cough, wheeze, or have trouble breathing during or after activity? | Yes/No | | | |
| 3. Have you ever been hospitalized overnight? | Yes/No | 28. Do you have asthma? | Yes/No | | | |
| 4. Have you ever had surgery? | Yes/No | 29. Do you have seasonal allergies that require medical treatment? | Yes/No | | | |
| 5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? | Yes/No | 30. Do you use any special protective or corrective equipment 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)? | Yes/No | | | |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | Yes/No | 31. Have you had any problems with your eyes or vision? | Yes/No | | | |
| 7. Do you have any allergies for example, pollen, latex, medicine, food or stinging insects? | Yes/No | 32. Do you wear glasses, contacts or protective eyewear? | Yes/No | | | |
| 8. Have you ever had a rash or hives develop during or after exercising? | Yes/No | 33. Have you ever had a sprain, strain, or swelling after injury? | Yes/No | | | |
| 9. Have you ever passed out during or after exercise? | Yes/No | 34. Have you ever broken or fractured any bones or dislocated any joints? | Yes/No | | | |
| 10. Have you ever been dizzy during or after exercise? | Yes/No | 35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? | | | | |
| 11. Have you ever had chest pain during or after exercise? | Yes/No | <i>If yes check appropriate blank and explain below:</i> | | | | |
| 12. Do you get tired more quickly than your friends do during exercise? | Yes/No | ___ Head | ___ Elbow | ___ Hip | ___ Back | ___ Shin/Calf |
| 13. Have you ever had racing of your heart or skipped heartbeats? | Yes/No | ___ Neck | ___ Forearm | ___ Thigh | ___ Wrist | ___ Shoulder |
| 14. Have you had high blood pressure or high cholesterol? | Yes/No | ___ Knee | ___ Chest | ___ Hand | ___ Hand | ___ Finger |
| 15. Have you ever been told you have a heart murmur? | Yes/No | ___ Ankle | ___ Upper Arm | ___ Foot | | |
| 16. Has any family member or relative died of heart problems or sudden death before age 50? | Yes/No | 36. Do you want to weigh more or less than you do now? | Yes/No | | | |
| 17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | Yes/No | 37. Do you lose weight regularly to meet weight requirements for your sport? | Yes/No | | | |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems? | Yes/No | 38. Do you feel stressed out? | Yes/No | | | |
| 19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)? | Yes/No | 39. Have you ever been diagnosed with sickle cell anemia? | Yes/No | | | |
| 20. Have you ever had a head injury or concussion? | Yes/No | 40. Have you ever been diagnosed with having the sickle cell trait? | Yes/No | | | |
| 21. Have you ever been knocked out, become unconscious or lost your memory? | Yes/No | 41. Record the dates of your most recent immunizations (shots) for: | | | | |
| 22. Have you ever had a seizure? | Yes/No | Tetanus _____ Measles _____ | | | | |
| 23. Do you have frequent or severe headaches? | Yes/No | Hepatitis B: _____ Chickenpox: _____ | | | | |
| 24. Have you ever had numbness or tingling in your arms, hands, legs or feet? | Yes/No | FEMALES ONLY (OPTIONAL) | | | | |
| 25. Have you ever had a stinger, burner or pinched nerve? | Yes/No | 42. When was your first menstrual period? _____ | | | | |

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, we understand and acknowledge that we are hereby advised that the student should undergo 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 ____/____/____

(WHERE DIVORCED OR SEPARATED, PARENT/GUARDIAN WITH LEGAL CUSTODY MUST SIGN)

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION

This completed form must be kept on file at the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2.

Part 3. Physical Examination (to be completed by licensed osteopathic physician, licensed chiropractic physician, licensed physician or certified advanced medicine 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

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: _____

_____ Cleared after completing evaluation/rehabilitation for: _____ For: _____

Recommendations: _____

Name of Physician/Physician Assistant/Nurse Practitioner

(print): _____

Address: _____ City: _____ Zip: _____

SIGNATURE OF PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER _____ DATE _____

School District of Okaloosa County
Student Intervention Services

MIS 5384
5.9.2016

Middle School Athletic Conference Consent and Release from Liability Certificate for Concussions, Sudden Cardiac Arrest and Heat Related Illness

This 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: PRYOR MIDDLE SCHOOL

District: OKALOOSA

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 a 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 a 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 a 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 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 suggest 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, Amyotrophic 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 coach 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.

Name of Student Athlete (printed)

Signature of Student-Athlete

Date

Name of Parent/Guardian (printed)

Signature of Parent/Guardian

Date

Okaloosa County School District
Student Intervention Services

Middle School Athletic Conference Consent and Release from Liability Certificate for Concussions

This 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: PRYOR MIDDLE SCHOOL

School District: OKALOOSA

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 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 use of an AED. Training is encouraged through agencies that provide hands-on training and other certificates that include an expiration date.

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 acknowledge 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

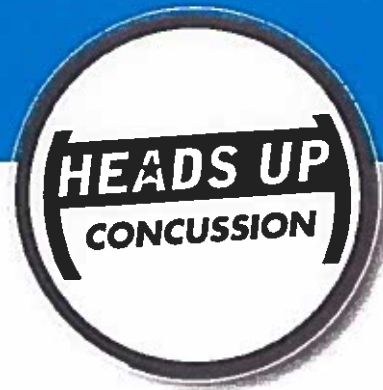
____/____/____
Date

Name of Parent/Guardian (printed)

Signature of Parent/Guardian

____/____/____
Date

PARENT & ATHLETE CONCUSSION INFORMATION SHEET



WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

▶ **"IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON"**

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.
2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.
3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

STUDENT-ATHLETE NAME PRINTED

STUDENT-ATHLETE NAME SIGNED

DATE

PARENT OR GUARDIAN NAME PRINTED

PARENT OR GUARDIAN NAME SIGNED

DAT

OKALOOSA COUNTY SCHOOL DISTRICT
STUDENT SERVICES

MIS 3513
12/2016

MIDDLE SCHOOL ATHLETIC CONFERENCE RULES AND REGULATIONS (CONDENSED)

Dear Parents:

Please read the rules at the bottom of this sheet then sign the top half of the sheet. Also, detach the bottom for your copy. We have read and understand the condensed rules of the OCMSAC on this form. We know of no reason why the student should not be eligible to participate in OCMSAC athletics and the student agrees to follow the rules of his/her school and the OCMSAC. We understand the risks that are associated with participating, including serious injury and even death. We voluntarily accept any and all responsibility for the student's safety while participating and agree to take no legal action against the OCMSAC, the Okaloosa County School District and/or employees and/or representatives of the Okaloosa County School District.

Student Signature: _____ Date: _____

Parent Signature : _____ Date: _____

(whether divorced or separated, parent/guardian with legal custody must sign)

ATTENTION STUDENT AND PARENT(S)/GUARDIAN(S)

Your school is a member of the Okaloosa County Middle School Athletic Conference (OCMSAC) and follows established rules.

A school district or charter school may not delay eligibility or otherwise prevent a student participating in controlled open enrollment, or a choice program, from being immediately eligible to participate in interscholastic and interscholastic extracurricular activities.

To be eligible to represent your school in interscholastic athletics student must:

1. Must be regularly enrolled and in regular attendance at your school. If the student is a home school student or attends a charter school, the student must declare in writing his/her intention to participate in athletics to the school at which the student is permitted to participate.
2. Must maintain a minimum 2.0 grade point average on a 4.0 scale and pass 5 subjects for the grading period immediately preceding participation or student eligibility for the first grading period for each new school year shall be based on passing 5 subjects and eligibility determined by their first grading period.
3. A student may not participate in a sport if the student participated in that same sport at another school during that school year. Florida Statute 1006.15
4. Once a student has been reported for eligibility in a particular activity, he/she may not become eligible in any other activity until the season for the activity in which he/she was reported eligible has ended.
5. The limit of eligibility for each student shall be six (6) consecutive semesters from the time the student initially enters the sixth grade.
6. Must have signed permission to participate from the student's parent(s)/guardian(s) provided to the school.
7. Any student who becomes 15 years of age on or after September 1 may participate in interscholastic athletics during the entire school year so far as age is concerned. However, any student who becomes 15 years of age on or before August 31 shall be ineligible for one year.
8. Must undergo a pre-participation physical evaluation and be certified as being physically fit for participation in interscholastic athletics. The physical evaluation is valid for 365 calendar days from the date that it was administered after which time the student must successfully undergo another physical evaluation to continue his/her participation.
9. 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.
10. 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.
11. Must not provide false information at his/her school.
12. Foreign exchange and international students must be approved by the Okaloosa County Middle School Athletic Conference Committee prior to any participation.

*If the student is declared or ruled ineligible due to one or more of the rules of OCMSAC, the student has the right to request that his/her school file an appeal on behalf of the student. See your principal or athletic director for information regarding this process.

OKALOOSA COUNTY SCHOOL DISTRICT
STUDENT INTERVENTION SERVICES

CONSENT FOR ImPACT NEUROCOGNITIVE TESTING AND RELEASE OF INFORMATION
FOR ATHLETIC PARTICIPATION IN OKALOOSA COUNTY

PLEASE CHECK AND COMPLETE SECTION "A" OR "B" AND SIGN AT THE BOTTOM

 Section A

I give my permission for (name of child) _____
(Date of Birth) _____ to take the ImPACT Neurocognitive baseline concussion test administered by the Okaloosa School District system through any of its designated employees and/or approved volunteers. I give permission for my child to provide all the information requested necessary to complete the test. I understand that my child may need to be tested more than once, depending on the validity of the testing results.

I also understand that the test results of the ImPACT Neurocognitive test may be released to my child's guidance counselor and teachers, including Principals, Athletic Coaches and trainers, and nurses for the purpose of providing temporary academic and athletic modifications if necessary for concussion management. I also consent to the release of the ImPACT testing results to any Medical Physician, who in the treatment of my concussed child, submits a request for release of medical records complaint to State and Federal guidelines.

I understand that I may revoke this consent for Neurocognitive testing at any time; however, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality.

 Section B

I **do not** give my permission for (name of child) _____
(Date of Birth) _____ to take the ImPACT Neurocognitive baseline concussion test administered by the Okaloosa School District system.

Parent(Guardian) Signature _____ Date _____

Student Signature _____ Date _____

OKALOOSA COUNTY SCHOOL DISTRICT
OFFICE OF RISK MANAGEMENT AND INSURANCE

AGREEMENT GOVERNING THE USE OF PRIVATE AUTOS FOR SCHOOL BUSINESS

Complete the following for each privately owned vehicle to be used for transporting students to and from related activities.

TO BE COMPLETED BY VEHICLE OWNER

Model of Vehicle _____ Name of Owner (Print) _____
Year of Vehicle _____ Name of Driver (Print) _____
Make of Vehicle _____ Vehicle Tag Number _____

I certify that the above described vehicle, which is to be used only for the approved transportation purposes set forth below, is covered by bodily injury liability insurance equaling or exceeding \$200,000 per person / \$300,000 per occurrence and personal injury protection ("No-Fault") coverage equaling or exceeding \$10,000 per person and that I will maintain the required insurance coverages at all times while my vehicle is used for student transportation. In the event of an accident while the vehicle is operated on school business, I will report all details of the accident to the school principal or his/her designee as soon as possible but in no event any later than 24 hours after the accident and understand that the financial loss for damage to my vehicle shall NOT be reimbursable by the District or the District Self-Insurance Fund.

This coverage is with _____ Insurance Company and expires on _____
Month/Day/Year

This vehicle complies with the Federal Motor Vehicle Safety Standards. (Verification of compliance is normally reflected by a sticker located in the door well of the driver's door.) Yes ___ No ___ NOTE: If No, the vehicle is NOT to be used for transporting students.

Signature of Owner _____ Date _____

Address _____ City _____ State _____

Zip Code _____ Home Phone (_____) _____ Cell Phone (_____) _____

TO BE COMPLETED BY VEHICLE DRIVER

Driver's License: State _____ Number _____

I understand that I am authorized to use only the aforementioned vehicle for transportation of students, and that I am only authorized to transport students for the purpose of _____ (e.g. field trip, illness, recreational outing, interscholastic competition, etc.) to the following location and back _____ and that I am not to deviate from the authorized transportation destinations. This authorization to transport students must be granted by the school principal or his/her designee and is required for each event or activity for which I provide transportation. I understand that I cannot provide transportation to pupils until my driving record has been checked by the school district and it is confirmed that I have not had more than three driving infractions in the past three years or a DUI in the past ten years.

I understand that all passengers will be seated in designated seating positions and shall be required to use the occupant crash protection system provided by the vehicle manufacturer.

Signature of Driver _____ Date _____

Address _____ City _____ State _____

Zip Code _____ Home Phone (_____) _____ Cell Phone (_____) _____

TO BE COMPLETED BY THE SCHOOL PRINCIPAL OR DESIGNEE

School _____ Teacher / Sponsor _____

The above driver and vehicle is approved to transport students on _____ (Date).

Signature of Principal or Designee _____ Date _____