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

OKALOOSA COUNTY SCHOOL DISTRICT

MIDDLE SCHOOL INTERSCHOLASTIC ATHLETICS PARENTAL PERMISSION, HOLD HARMLESS 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 OFFICERS. 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 CANNOT 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 OFFICERS, 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 SCHOOL BOARD, ITS OFFICERS, 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:** _____ **Female/Male**

Address: _____ **Home Phone:** _____

City: _____ **Zip:** _____ **Emergency Phone:** _____

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

PLEASE COMPLETE ALL PARTS:

PART I – PARENTAL/GUARDIAN PERMISSION, ACKNOWLEDGEMENT, HOLD HARMLESS, AND RELEASE

A. I, _____ herby grant permission for _____ (Student Athlete) to participate at _____ School during the school year, and I know of, and acknowledge that my child/ward knows of the risks involved in interscholastic athletic participation, and 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, Okaloosa County School District, its School Board, its officers, employees, agents, or assigns (the "Released Parties"), 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, and assigns, because of any accident or mishap involving the athletic participation of my child/ward. As required by F.S. 1014.06(1), I specifically authorize healthcare services to be provided for my child/ward by a healthcare practitioner, as defined in F.S. 456.001, or someone under the direct supervision of a healthcare practitioner, 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 the disclosure of my child's/ward's individually identifiable health information should treatment or illness or injury become necessary. I understand the Okaloosa County School District requires all students participating in interscholastic athletics be covered by a medical insurance policy providing minimum coverage of $25,000 for medical expenses. I hereby certify that _____ (Student Athlete) 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 our 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, and promotional and commercial materials without reservation or limitation. The Released Parties, however, are under no obligation to exercise said rights herein.

C. I also herby 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 to contact 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 dentists 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. (Please list medications, allergies, etc. 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 Athlete) 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 _____ 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/ward's protected health information is protected by federal regulations under the Health Information Probability 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 redisclosure 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 anytime by notifying in writing the school's athletic director, but if I do, it will not have any effect on the actions the Okaloosa County School District 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 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 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 (EL3CH) 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 FORM AND KNOW IT CONTAINS A HOLD HARMLESS RELEASE.

_____	_____	_____
Date	**Printed Name of Parent/Guardian**	**Signature of Parent/Guardian**

STATE OF FLORIDA – COUNTY OF OKALOOSA

The foregoing instrument was acknowledged before me by means of ___ physical presence or ___online notarization, this _____ day of _____, 20___, by _____.
Name of Person Acknowledged

_____
Signature of Notary Public – State of Florida

(Notary Seal)

_____
Name of Notary (Typed, Printed, or Stamped)

Personally Known ___ OR Produced Identification ___
Type of Identification Produced:

_____

MIS 6347
Rev. 1.13.2021

OKALOOSA COUNTY SCHOOL DISTRICT/STUDENT INTERVENTION SERVICES

MIDDLE SCHOOL ATHLETIC CONFERENCE 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.
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:_____ 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 / N0
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?	
4. Have you ever had surgery?	YES / NO	29. Do you have seasonal allergies that require medical treatment?	
5. Are you currently taking any prescription or non-prescription (over the counter) medications or pill or using an inhaler?	YES / NO	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?	
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 ever had any problems with your eyes or vision?	
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?	
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?	
9. Have you ever passed our during or after exercise?	YES /NO	34. Have you ever broken or fractured any bones or dislocated any joints?	
10. Have you ever been dizzy during or after exercise?	YES / NO	35. Have you ever 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 ___Back ___Neck ___Shin/Calf ___Forearm ___Thigh ___Wrist ___Knee ___Shoulder ___Chest ___Hand ___Finger ___Ankle ___Upper Arm ___Foot	
11. Have you ever had chest pain during or after exercise?	YES / NO	36. Do you want to weigh more or less than you do now?	
12. Do you get tired more quickly than your friends do during exercise?	YES /NO	37. Do you lose weight regularly to meet weight requirements for your sport?	
13. Have you ever had racing of your heart or skipped heartbeats?	YES / NO	38. Do you feel stressed out?	
14. Have you had high blood pressure or high cholesterol?	YES / NO	39. Have you ever been diagnosed with having sickle cell anemia?	
15. Have you ever been told you have a heart murmur?	YES /NO	40. Have you ever been diagnosed with having the sickle cell trait?	
16. Has any family member of relative died of heart problems or sudden death before age 50?	YES / NO	41. Record the dates of your most recent immunizations (shots for: Tetanus_____ Measles _____ Hepatitis B_____ Chickenpox_____	
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	YES / NO	FEMALES ONLY (OPTIONAL) 42. When was your first menstrual period?	
18. Has a physician ever denied or restricted your participation in sports for any heart problem?	YES /NO	43. When was your most recent menstrual period?	
19. Do you have any current skim problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores?	YES / NO	44. How much time do you usually have from the start of one period to the start of another?	
20. Have you ever had a head injury or concussion?	YES / NO	45. How many periods have you had in the last year?	
21. Have you ever been knocked out, become unconscious or lost your memory?	YES /NO	46. What was the longest time between periods in the last year:	
22. Have you ever had a seizure?	YES / NO	Explain "yes answers here: _____	
23. Do you have frequent or sever headaches?	YES / NO		
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	YES /NO		
25. Have you ever had a stinger, burner or pinched nerve?	YES / NO		

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**

ATHLETIC PRE-PARTICIPAITON PHYSICAL EVALUATION

The 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.

(if applicable)

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under t 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): _____

Address: _____ City: _____ Zip: _____

_____ _____

Signature of Physician **Date**

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

MIS 5384
5.9.2016

School District of Okaloosa County

Student Intervention Services

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: _____ **School District** _____

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

MIS 5348
3/2023

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 forNeurocognitive 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 County School District.

Parent(Guardian) Signature_____ Date_____

Student Signature_____ Date_____

MIS 5384
5.9.2016

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: _____ School District _____

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 the annual requirement for my child/ward to view both the "Sudden Cardiac Arrest" and "Heat-Related Illness" courses www.nfhslearn.org. I acknowledge that the information on Sudden Cardiac Arrest and Heat-Related Illness have been read and understood. 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
		____/____/____

HEADS UP CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR PARENTS

What is a concussion?

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

You can't see a 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 your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

What are the signs and symptoms of a concussion?

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs of a concussion:

SYMPTOMS REPORTED BY ATHLETE	SIGNS OBSERVED BY PARENTS/GUARDIANS
• 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 "feeling down"	• 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

How can you help your child prevent a concussion or other serious brain injury?

- Ensure that they follow their coach's rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all tim
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serio brain injury or skull fracture.
  - However, helmets are not designed to prevent concussions. There is no "concussion-proof" helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

What should you do if you think your child has a concussion?

SEEK MEDICAL ATTENTION RIGHT AWAY. A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return regular activities, including sports.

KEEP YOUR CHILD OUT OF PLAY. Concussions take time to heal. Don't let your child return to play the day of the inju and until a health care professional says it's OK. Children w return to play too soon—while the brain is still healing—risk a greater chance of having a repeat concussion. Repea or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetim

TELL YOUR CHILD'S COACH ABOUT ANY PREVIOUS CONCUSSION. Coaches should know if your child had a previous concussion. Your child's coach may not know ab a concussion your child received in another sport or activ unless you tell the coach.

If you think your teen has a concussion:
Don't assess it yourself. Take him/her out of play. Seek the advice of a health care professional.

It's better to miss one game than the whole season.

For more information, visit **www.cdc.gov/Concussion**.

OKALOOSA COUNTY SCHOOL DISTRICT
STUDENT SERVICES
MIDDLE SCHOOL ATHLETIC CONFERENCE RULES AND REGULATIONS (CONDENSED)

MIS 3513
12/2016

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)

---------- detach here ----------

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.

Assumption of Risk and Waiver of Liability Relating to COVID-19 (Participants)

The novel coronavirus ("COVID-19") has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Saint Mary Catholic School (NAME OF PARISH/SCHOOL) has put in place preventative measures to reduce the spread of COVID-19; however, we cannot guarantee that you or your child(ren) (specifically named herein below) will not become infected with COVID-19. Furthermore, attending summer camps, activities, programs, functions, or gatherings of any kind sponsored by Saint Mary Catholic School (NAME OF PARISH/SCHOOL) could increase your or your child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected with COVID-19 by attending summer camps, activities, programs, functions, or gatherings and that such exposure or infection may result in infection, illness, personal injury, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 may result from the actions, inactions, omissions, or negligence of myself, my child(ren), and/or others, including, but not limited to, clergy, teachers, employees, staff, coaches, volunteers, and other participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any infection, illness, sickness, damage, loss, expense, and/or liability of any kind (including, but not limited to, personal injury, disability, and death) (hereinafter "Claims"), that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at summer camps, activities, programs, functions, or gatherings of any kind sponsored by Saint Mary Catholic School (NAME OF PARISH/SCHOOL).

On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, and hold harmless Saint Mary Catholic School (NAME OF PARISH/SCHOOL), William A. Wack, as Bishop of the Diocese of Pensacola-Tallahassee, the Diocese of Pensacola-Tallahassee, and all of their current, former, and future representatives, agents, clergy, teachers, employees, staff, coaches, and volunteers (collectively, "the Diocese") of and from all Claims, including all liabilities, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this assumption of risk, waiver, and release includes any Claims based on the actions, inactions, omissions, or negligence of the Diocese, whether a COVID-19 infection occurs before, during, or after participation in any summer camps, activities, programs, functions, or gatherings of any kind sponsored by Saint Mary Catholic School (NAME OF PARISH/SCHOOL).

This Assumption of Risk and Waiver of Liability Relating to COVID-19 is applicable to my child(ren) stated as follows:

_____ (Full Name and Date of birth)

_____ _____ _____ _____

Signature of Parent/Guardian (Date) (Witness) (Date)

_____ _____ _____

Print Name (Witness) (Date)

Rev. 6-4-2020

SAINT MARY SCHOOL OFF-CAMPUS IN COUNTY FIELD TRIP FORM

Dear Parent or Legal Guardian:

Your son/daughter will be participating in a school-sponsored activity requiring transportation to a location away from the school campus. This activity will take place under the guidance and supervision of employees from St. Mary School.

A brief description of the activity follows:

Name of the event: Saint Mary School Athletic events Destination: See sport specific schedule

Designated Supervisor of Activity: Team Coach

Date: See Schedule Departure Time: See Schedule Return Time: After event is completed

Method of Transportation: Auto Student Cost: no cost for travel

What to bring: Winning Attitude What to wear: proper sports attire

I will chaperone _____ Yes _____No

If yes...Name _____ phone # _____

If you would like your child to participate in this event, please sign, and return the following statement of consent and release of liability. As parent or legal guardian, you remain fully responsible for any legal responsibility which may result from any personal actions taken by the named student.

I hereby consent to participation by my child, _____ in the event described above. I understand that this event will take place away from the school grounds/diocesan property and that my child will be under the supervision of the designated employee on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation.

All players are responsible for missed assignments and tests.

Drivers must meet Diocesan Auto Insurance requirements. Contact school office for further info.

_____
(Print Parent/Guardian's Name)

_____
(Parent/Guardian's Signature)

_____
(Date)