Middle School Tampa Charter Athletic League

NAME: _____ AGE: _____

TEACHER: _____ GRADE: _____

PARENT NAME: _____

PARENT EMAIL: _____

PARENT CONTACT NUMBER: _____

Please Specify Sport(s):

Girls Soccer **Boys Flag Football** **Co-Ed Street Hockey**

Boys Soccer **Girls Volleyball** **Co-Ed Cross Country**

****** PLEASE SPECIFY SIZES FOR UNIFORMS ******

SHIRT SIZE (CIRCLE ONE): Youth L XL

Adult S M L XL XXL

**** SCHEDULE AND RULE INFORMATION CAN BE FOUND ON TAMPA CHARTER ATHLETIC LEAGUE WEBSITE AT: WWW.TAMPACHARTERLEAGUE.WEEBLY.COM ****

Sports Participation Requirements

1. Your child needs a sports physical. Their well visit physical is NOT the same. Your doctor will have the form. Initial_____

2. If your child has had a sports physical done within the last year, we will simply need a copy of the completed form. Initial _____

3. All required items need to be turned in by the date posted by LGCS for each sport (***including fees***) or your child will not be able to participate. If your child does not make the team your money will be refunded. Initial _____

4. Once your child has joined the team, the $120 enrollment fee is non-refundable under any circumstance. Initial _____

5. Your child needs to maintain a "D" average in each class in order to be able to be eligible for participation. Once they drop below that average they are automatically suspended from the team until they raise it to the appropriate level. Their scores will be evaluated each Friday to determine eligibility for following week. Initial _____

6. If your student is absent from school for any length of time for an illness related reason, they are NOTeligible to play that day under any circumstance.
Initial _____

7. You are responsible for timely pickup of your child after practice and games rd (10 minutes). The 3 time there is an issue the coach and administration has the right to not let your child return to the team. Initial_____

8. Your child is responsible for their behavior both on and off the field. If there is an issue during an athletic event or at school the coach and administration reserve the right to make your child ineligible for a designated period of time.
Initial _____

9. The liability waiver needs to be a notarized in order for it to be considered complete.
Initial____

Signature_____

Date_____

Insurance Information

Name:_____

Grade: _____

Address:_____

Mother's
name:_____

—

Father's
Name:_____

Email
Address:_____

Emergency Contact: (that can be reached during practices)

Emergency Contact
Name:_____

Telephone :

_____

Medical Insurance Carrier:

_____

Medical ID #:

_____

Athletic Liability Waiver and Release by Parent/Guardian of Learning Gate Community School Student

I the undersigned Parent/Guardian on behalf of my child, _____ (hereinafter referred to as ***Child***) does hereby waive and release, indemnify, hold harmless and forever discharge Learning Gate Community School, Hillsborough County Schools and Learning Gate Education Foundation, including its agents, employees, officers, directors, affiliates, volunteers, successors and assigns, of and from any and all claims, demands, debts, contracts, expenses, causes of action, lawsuits, damages and liabilities, of every kind and nature, whether known or unknown, in law or equity, that I or ***Child*** ever had or may have, arising from or in any way related to ***Child's*** participation in any of the training, camps, or related physical activities, conducted by, on the premises of, Learning Gate Community School, provided that this waiver of liability does not apply to any acts of gross negligence, or intentional, willful or wanton misconduct. Learning Gate Community School, Hillsborough County Schools and Learning Gate Education Foundation, its agents, employees, officers, directors, affiliates, successors and assigns are hereby jointly and severally referred to herein as ***Released Parties.*** This waiver and release includes (but is not limited to) any injuries to ***Child*** resulting from ***Child's*** participation in any of the Learning Gate Community School athletic programs conducted by ***Released Parties*** as well as injuries resulting from engaging in Learning Gate Community School athletic practice, game, activity, contest, event or other related program.

I understand that the activities that said ***Child*** will participate in can be dangerous and may cause serious or grievous injuries, including bodily injury and/or death. On behalf of myself, ***Child,*** my heirs, assigns and next of kin, I and said ***Child*** waive all claims for damages, injuries and death sustained by me that I or said ***Child*** may have against ***Released Parties***regarding any such activity.

Child has the necessary and requisite skills to participate in all facets of, and activities of and requested of ***Released Parties*** except as noted below. The nature of the activities has been fully disclosed and any flyer, advertisement, or brochure relating to the participating activities is expressly made a part of this **Waiver and Release.**

By this **Waiver and Release,** I, on behalf of said ***Child,***assume any risk, and take full responsibility and waive any claims of personal injury or death associated with practicing and/or engaging in Learning Gate Community School athletic programs conducted by ***Released Parties.***

This **Waiver and Release** contains the entire agreement between the parties, and supersedes any prior written or oral agreements concerning the subject matter of this **Waiverand Release.** The provisions of this may be waived, altered, amended or repealed, in whole or in part, only upon the prior written consent of all parties.

The provision of this **Waiver and Release** will continue in full force and effect even after the termination of the activities conducted by, on the premises of, or for the benefit of ***Released Parties***, whether by agreement, by operation of law, or otherwise.

I have read, understand and fully agree to the terms of this **Waiver and Release.** I understand and confirm that by signing this **Waiver and Release** said ***Child*** and I have given up considerable future legal rights. I have signed this Agreement freely, voluntarily, under no duress or threat of duress, without inducement, promise or guarantee being communicated to me. My signature is proof of my intention to execute a complete and unconditional **Waiver and Release** of all liability to the full extent of the law.

Medical Conditions.

Child is subject to the following allergies or medical conditions, and I authorize *Released Parties* to disclose these conditions to a physician or other medical professional in the event said *Child* should require emergency medical care:

_____

_____

_____

Prohibited Activities.
As a result of the above-mentioned medical conditions, I, on behalf of *Child*,am prohibiting involvements in the following specific activities:

_____

_____

_____

Permissible Activities.
As a result of the above-mentioned medical conditions, I, on behalf of *Child*,am allowing involvements in the following specific activities:

_____

_____

_____

_____
Printed Name of CHILD

_____
Printed Name of Parent (Guardian)

_____
Signature of Parent (Guardian)

WITNESS my signature on the ____ day of _____, 20____.

Signature of Notary _____

Seal:

EL2

Revised 05/17

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 Thigh
___ Neck	___ Forearm	___ Knee
___ Back	___ Wrist	___ Shin/Calf
___ Chest	___ Hand	___ Ankle
___ Shoulder	___ Finger	___
___ 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			
10. Neurological			
11. Psychiatric			
MUSCULOSKELETAL			
12. Neck			
13. Back			
14. Shoulder/Arm			
15. Elbow/Forearm			
16. Wrist/Hand			
17. Hip/Thigh			
18. Knee			
19. Leg/Ankle			
20. 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: _____