

ALL FORMS AND INFORMATION SHEETS IN THIS PACKET ARE REQUIRED FOR PARTICIPATION IN TRYOUTS, PRACTICES, OR CONTESTS DURING THE 2024-2025 SCHOOL YEAR!

NO SUBSTITUTE FORMS CAN BE ACCEPTED!!!

Dear Parent/Guardian,

Florida State Statutes mandates that every student athlete must have a Pre-participation Physical Evaluation (EL2), Consent and Release from Liability form (EL3) and a Consent and Release from Liability Certificate to participate in Athletics. In addition Brevard Public Schools also requires the athlete and parent to sign Cardiology Report: Electrocardiogram (ECG). **Please remember that Florida State Statute mandates that athletic physicals are only valid for 365 days. All other forms in the packet must be completed at least once each school year before the start of the sport season.**

Hoover Middle School respectfully requests if possible that the physical be completed after June 1st each year in order to be valid for the entire school year. That helps make sure that your son/daughter has a valid physical throughout the entire school year (August thru May).

You may get the physical evaluation completed by the Physician/Physician Assistant/Nurse Practitioner of your choice after June 1st to be valid for the entire school year. **On page 3 of the physical, the Physician must sign, date and stamp their identifying information. Florida State Statutes also requires every athlete to have health insurance coverage in order to participate.** Please be sure to include the insurance company name and policy number for your family health insurance plan on page 1, part 2, item G on the EL3 form.

If you need to purchase insurance coverage so that your child can participate, BPS has entered into an agreement with School Insurance of Florida that offers athletic and school insurance coverage plans for all students. You can access their plans and fee schedule at their website located at www.schoolinsuranceofflorida.com. Their toll-free number is 1-800-432-6915. **I encourage you to consider purchasing this reasonably priced coverage even if your child is covered by your own family health plan. It will help pay towards some of your out of pocket deductibles up to certain limits.**

You will need to complete and turn in all the forms in this packet BEFORE your child can participate in athletic tryouts. I appreciate, in advance, your cooperation in completing this packet as requested. Please do not hesitate to contact me at Sadowski.brenda@brevardschools.org if you have any questions.

Sincerely,

Brenda Sadowski
Athletic Director



Hoover Middle School Student Athletic Packet

Student Name: _____ Student Number: _____

Date of Birth: _____ Age: _____ Grade: 7 / 8 Gender: Female / Male

Parent: _____ Phone: _____

Parent: _____ Phone: _____

Eligibility to tryout or participate in any sport:

- Completed Sports Physical Packet (a new packet must be completed each school year—We recommend after June 1)
 - EL 2 must be cleared by a physician.
 - EL3 must include completed insurance information (if you do not have insurance, it can be purchased through schoolinsurancofflorida.com)
 - ECG
 - BPS Hazing Course Consent form
 - Transportation form
- Students must have a minimum of a 2.0 GPA.
- Students are ineligible if they turned 15 prior to July 1, 2024

Student Athlete Agreement

1. Student athletes will maintain a C or above in all classes.
2. Student athletes will maintain good behavior and not get any detentions or referrals.
3. Student athletes will arrive to practice and get picked up on time.
4. Students will demonstrate good sportsmanship.
5. Student athletes will represent themselves, the team, and the school well on social media.
6. The coach's discretion will be used for consequences for not meeting the above expectations.
7. Disciplinary action resulting in suspension will result in missing a game/meet during the season.
8. A second suspension, major infractions or excessive infractions during the season will result in the removal from the team.

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____



PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/24

MEDICAL HISTORY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Biological Sex: _____ Age: _____ Date of Birth: ____/____/____
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ City/State: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____ Relationship to Student: _____
 Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
 Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

List past and current medical conditions:

Have you ever had surgery? If yes, please list all surgical procedures and dates:

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

Patient Health Questionnaire version 4 (PHQ-4)

Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)

	Not at all	Several days	Over half of the days	Nearly everyday
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

GENERAL QUESTIONS		Yes	No	HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.				<i>(continued)</i>			
1	Do you have any concerns that you would like to discuss with your provider?			8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
2	Has a provider ever denied or restricted your participation in sports for any reason?			9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
3	Do you have any ongoing medical issues or recent illnesses?			10	Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No
4	Have you ever passed out or nearly passed out during or after exercise?			11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash)		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			12	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
7	Has a doctor ever told you that you have any heart problems?						

This form is not considered valid unless all sections are complete.



PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/24

Student's Full Name: _____ Date of Birth: ___ / ___ / ___ School: _____

BONE AND JOINT QUESTIONS		Yes	No	MEDICAL QUESTIONS (continued)		Yes	No
14	Have you ever had a stress fracture?			26	Do you worry about your weight?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			27	Are you trying to or has anyone recommended that you gain or lose weight?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?			28	Are you on a special diet or do you avoid certain types of foods or food groups?		
MEDICAL QUESTIONS		Yes	No	29	Have you ever had an eating disorder?		
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?			Explain "Yes" answers here: _____ _____ _____ _____ _____ _____ _____ _____			
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?						
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?						
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?						
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?						
22	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?						
23	Have you ever become ill while exercising in the heat?						
24	Do you or does someone in your family have sickle cell trait or disease?						
25	Have you ever had or do you have any problems with your eyes or vision?						

This form is not considered valid unless all sections are complete.

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. Florida Statute 1006.20 requires a student candidate for an interscholastic athletic team to successfully complete a preparticipation physical evaluation as the first step of injury prevention. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

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 physical evaluation required by Florida Statute 1006.20, 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 (ECG), echocardiogram (ECHO), and/or cardio stress test. The FHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____ (printed) Student-Athlete Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ (printed) Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ (printed) Parent/Guardian Signature: _____ Date: ___ / ___ / ___



PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/24

PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ___ / ___ / ____ School: _____

HEALTHCARE PROFESSIONAL REMINDERS:

Consider additional questions on more sensitive issues.

• Do you feel stressed out or under a lot of pressure?	• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Do you drink alcohol or use any other drugs?	• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	• Have you experienced performance changes, felt fatigued, and/or experienced times of low energy during the past year?

Verify completion of FHSAA EL2 Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

EXAMINATION

Height: _____ Weight: _____

BP: ___ / ___ (___ / ___) Pulse: _____ Vision: R 20/ _____ L 20/ _____ Corrected: Yes No

MEDICAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 		
Eyes, Ears, Nose, and Throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph Nodes		
Heart <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis 		
Neurological		

MUSCULOSKELETAL - healthcare professional shall initial each assessment

MUSCULOSKELETAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and Arm		
Elbow and Forearm		
Wrist, Hand, and Fingers		
Hip and Thigh		
Knee		
Leg and Ankle		
Foot and Toes		
Functional <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 		

This form is not considered valid unless all sections are complete.

*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. The FHSAA Sports Medicine Advisory Committee strongly recommends to a student-athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___ / ___ / ____

Address: _____ Phone: (____) _____ E-mail: _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____



PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/24

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Biological Sex: _____ Age: _____ Date of Birth: ____/____/____
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ City/State: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____ Relationship to Student: _____
 Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
 Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

The preparticipation physical evaluation must be administered by a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with the practitioner's regulatory board. (§1006.20(2)(c), F.S.)

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

Medically eligible for only certain sports as listed below:

Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

I hereby certify that I, or a clinician under my direct supervision, have examined the above-named student-athlete using the FHSAA EL2 Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date of Exam: ____/____/____
 Address: _____ Phone: (____) _____
 Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp *(if required by school)*

Medications: *(use additional sheet, if necessary)*

List: _____

Relevant medical history to be reviewed by athletic trainer/team physician: *(explain below, use additional sheet, if necessary)*

- Allergies Asthma Cardiac/Heart Concussion Diabetes Heat Illness Orthopedic Surgical History Sickle Cell Trait Other

Explain: _____

Signature of Student: _____ Date: ____/____/____ Signature of Parent/Guardian: _____ Date: ____/____/____

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct. 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 (ECG), echocardiogram (ECHO), and/or cardio stress test.

This form is not considered valid unless all sections are complete.

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PREPARTICIPATION PHYSICAL EVALUATION (Supplement)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/24

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

MEDICAL ELIGIBILITY FORM - Referred Provider Form

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Biological Sex: _____ Age: _____ Date of Birth: ___ / ___ / ___
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ City/State: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____ Relationship to Student: _____
 Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
 Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

Referred for: _____ Diagnosis: _____

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

- Medically eligible for all sports without restriction as of the date signed below
- Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

Medically eligible for only certain sports as listed below:

Not medically eligible for any sports

Further Recommendations: *(use additional sheet, if necessary)*

Name of Healthcare Professional (print or type): _____ Date of Exam: ___ / ___ / ___

Address: _____ Phone: (____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*



Florida High School Athletic Association
Consent and Release from Liability Certificate (Page 2 of 5)

EL3

Revised 3/23

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

School: _____ School District (if applicable): _____

Concussion Information

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

Signs and Symptoms of a Concussion:

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

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

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

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

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

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

Return to play or practice:

Following physician evaluation, the return to activity process requires the athlete to be completely symptom free, after which time they would complete a stepwise protocol under the supervision of a licensed athletic trainer, coach, or medical professional and then, receive written medical clearance from 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 student should be aware of preliminary evidence that suggests repeat concussions, and even hits that do not cause a symptomatic concussion, may lead to abnormal brain changes which can only be seen on an 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” at www.nfhslearn.com. I accept responsibility for reporting all injuries and illnesses to my parents, team doctor, athletic trainer, or coaches associated with my sport, including any signs and symptoms of concussion. I have read and understand the above information on concussion. I will inform the supervising coach, athletic trainer, or team physician immediately if I experience any of these symptoms or witness a teammate with these symptoms. Furthermore, I have been advised of the dangers or participation for myself and that of my child/ward.

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



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

School: _____ School District (if applicable): _____

Heat-Related Illness Information

Heat-related illness is a cause for concern for student-athletes who participate in high school sports in Florida. Especially vulnerable are those students who participate in conditioning and practices in the summer months and other times of extreme heat. Student-athletes 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 is not 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.

What are some common heat-related injuries in sports?

Exertional Heat Stroke (EHS): EHS is the most serious heat-related illness. EHS is a medical emergency. It happens when the body's temperature rises quickly, and the body cannot cool down. Student-athletes can die or become permanently disabled from EHS if not properly recognized and managed. EHS is one of the leading causes of death in young athletes, especially in Florida. The two main criteria for diagnosing EHS are rectal temperature >105F (40.5C) immediately post collapse and central nervous system (CNS) dysfunction. There are many signs and symptoms associated with EHS. Parents and student-athletes should familiarize themselves with these by viewing the free video resources provided by the National Federation of High School Sports (NFHS) or the FHSAA.

- EHS is preventable by taking the proper precautions and understanding the symptoms of someone who has become ill due to heat.
• EHS is survivable when quick action is taken by staff members that includes early recognition of symptoms and aggressive cold-water immersion.

Heat Exhaustion (EHI): Heat exhaustion is the most common heat-related condition observed in active populations including student-athletes. EHI is a type of heat-related illness. EHI is defined as the inability to continue exercise in the heat because the heart has difficulty providing enough oxygenated blood to all the working organs and muscles. It usually develops after several days practicing or conditioning in high temperature weather and not drinking enough fluids.

Heat Cramps: Heat cramps are painful, involuntary cramping often in the legs, arms, or abdomen with muscle contraction. Cramping usually occurs in the preseason conditioning phase when the body is not properly conditioned and more subject to fatigue. Heat cramps can easily be treated with rest, stretching of the muscle, and replacement of fluid and electrolytes. The exact mechanism of muscle cramps in warm environmental conditions is unknown but can be caused acutely by extensive dehydration and sodium losses or chronically via inadequate electrolytes in the athlete's diet. Although heat cramps are not a cause of sudden death, it can be confused with the more serious condition, exertional sickling.

Is my student at risk?

Yes, all student-athletes are vulnerable to exertional heat stroke and other heat-related injuries. While every student-athlete can succumb to EHS, newer data is reporting a high incidence of exertional heat stroke cases in football players, especially those who play the lineman position and in very lean distance runners. Research also states many reports of EHS emergencies are during summertime or preseason conditioning sessions. Other conditions that can increase your risk for heat-related illness include obesity, fever, dehydration, poor circulation, sunburn, and prescription drug or alcohol use.

What is the FHSAA doing to keep my student safe?

The FHSAA has published Policy 41, titled "Exertional Heat Illness". This policy provides specific procedures for schools to educate student-athletes and parents on EHI as well as strategies to prevent these injuries. FHSAA Policy 41 also provides procedures for schools to follow for preseason acclimatization, environmental monitoring, and the inclusion of cooling zones for the management of a student-athlete suffering from a heat injury.

How can I help to keep my student safe when it comes to the heat?

- Learn more about heat-related injuries in sports at https://www.nfhs.org/media/1015695/ksi-5-pillars-of-exertional-heat-stroke-prevention-2015.pdf
• Discuss nutrition, proper hydration, body weight, and the importance of sleep and rest with your family healthcare provider at the time fo the sports physical
• Talk to your school and coach about safeguards they have in place to keep kids safe in the heat and what they will do for someone who becomes ill or injured
• Monitor fluid intake of your student while at home and routinely check in with your student-athlete to inquire about how they feel
• Report any concerns with your school's athletic trainer, team physician, coach, or your family healthcare provider

By signing this agreement, I acknowledge the annual requirement for my child/ward to view the "Heat Illness Prevention" course at www.nfhslearn.com. I acknowledge that the information on Heat-Related Illness has been read and understood. I have been advised of the dangers of participation for myself and that of my child/ward.

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

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

Name of Student (printed) Signature of Student Date



Cardiology Report: Electrocardiogram (ECG)

In accordance with Board Policy 2431 Interscholastic Athletics, as part of the middle and high school athletic packets, The School Board of Brevard County, Florida is requiring each student athlete wishing to participate in middle school and/or high school athletics, to have an electrocardiogram (ECG) screening prior to participating in his/her first athletic sport in middle school. An athlete who had an ECG screening prior to participating in his/her first athletic sport in middle school would need a second ECG screening prior to participating in his/her first athletic sport in high school, unless a previous ECG screening was completed within the preceding 365 days. An athlete who did not participate in middle school athletics, and therefore had not had a previous ECG screening, would need to have an ECG screening prior to participating in his/her first athletic sport in high school.

Date: _____ Student's Name: (Print) _____

Name of School: _____

Sex: _____ Date of Birth: _____ Age: _____ Grade: _____ Student ID #: _____

An ECG screening has previously been completed and is on file at _____ School. My child has been cleared for participation in middle school athletics or high school athletics.

An ECG Screening was completed and evaluated by an outside vendor. Attached is the documentation clearing my child for participation in middle school athletics or high school athletics.

The following represents the findings of the licensed physician or practitioner after reviewing the ECG screening results for my child:

Cardiac Clearance:

(To be completed by a Licensed Physician or Practitioner*)

Low Risk/Cleared for Participation: _____ Higher Risk/Not Cleared for Participation: _____ Date: _____

Name of Licensed Physician or Practitioner*:

(Print Name)

(Signature)

Name of Office: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

I decline participation in the ECG screening on behalf of my child although I understand an ECG screening may assist in diagnosing several different heart conditions that may contribute to sudden cardiac death.

Parent/Legal Guardian Name Printed

Parent/Legal Guardian Signature

Parent/Legal Guardian Phone #

*See Section 1006.20(2)(c), Florida Statutes.

Consent Certificate for Participation

This completed form must be kept on file by the school. This form is valid for one year from the date of the most recent signature. The form is non-transferable; if a student changes schools during the validity period of the form, the form will need to be resubmitted to and kept by the new school.

School: _____ School District: **Brevard**

Hazing Information

Pursuant to Board Policy 5516 and Florida Statutes 1006.63:

Hazing activities of any type are inconsistent with and disruptive to the educational process, and prohibited at any time in school facilities, on school property, and/or off school property if the misconduct is connected to activities or incidents that have occurred on school property. No administrator, faculty member, or other Board employee shall encourage, permit, authorize, condone, or tolerate any hazing activities. No student shall plan, encourage, or engage in any hazing.

Hazing is defined as performing any action or situation that endangers the mental or physical health or safety of a student at a school for purposes including, but not limited to:

- A. initiation into any organization operating under the sanction of a District school;
- B. admission into any organization operating under the sanction of a District school;
- C. affiliation with any organization operating under the sanction of a District school; or
- D. the perpetuation or furtherance of a tradition or ritual of any organization operating under the sanction of a District school.

"Hazing" includes, but is not limited to, pressuring, coercing, or forcing a student into violating State or Federal law; any brutality of a physical nature, such as whipping, beating, branding or exposure to the elements, or forced consumption of any food, liquor, drug, or other substance, or other forced physical activity that could adversely affect the physical health or safety of the student; or any activity that would subject the student to extreme mental stress, such as sleep deprivation, forced exclusion from social contact, forced conduct that could result in extreme embarrassment, or other forced activity that could adversely affect the mental health or dignity of the student.

Statement of Student-Athlete Responsibility:

BPS has implemented required training for all student athletes regarding hazing prevention through completion of the NFHS (National Federation of State High School Associations) Hazing Prevention for students course available online. The official description of the course is:

"Every year, students across the country are affected by incidents of hazing. Together we can end the useless, counterproductive, and often dangerous practice of hazing. This hazing course has been designed to teach students how to identify hazing, when to step in when needed, and why they should notify the proper authorities. This course defines hazing and its many types, highlights why it is different

Kevin Robinson
District Director of Athletics



School Board of Brevard County

2700 Judge Fran Jamieson Way • Viera, FL 32940-6601

Mark J. Rendell, Ed.D., Superintendent



from bullying, and explains your power as a bystander and how you can change the culture of how you welcome new members. To learn more about hazing and the role you can play, take this free course.”

<https://nfhslearn.com/courses/hazing-prevention-for-students#crsOutline>

I acknowledge the annual requirement for my child/ward to complete the “Hazing Prevention for Students” course by NFHS at <https://nfhslearn.com/courses/hazing-prevention-for-students#crsOutline>. I have read and understand the above information pertaining to hazing and that it is against School Board Policy as well as Florida Statutes including constituting a crime. I will inform the supervising coach, athletic trainer, team physician, school principal and/or district staff immediately if I experience hazing or witness another student being hazed. I understand that it is my responsibility to conduct a full review of the Florida Statutes regarding hazing and to discuss with my child/ward.

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

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

Name of Student (printed) Signature Signature of Student Date

Kevin Robinson
District Director of Athletics



SCHOOL BOARD OF BREVARD COUNTY, FLORIDA

PARENT PERMISSION AND RESPONSIBILITY STATEMENT FOR OFF-CAMPUS
EXTRA-CURRICULAR ATHLETICS

Hoover M.S.

School Name

2024-2025

Date

Student's Name (please print)

Name of Sport(s)

Activity / Event:

(List the extra-curricular sport(s), anticipated contest dates and off-campus practice locations or attach the schedule for both to this form)

Brenda Sadowski
School Athletic Director

(321) 727-1611 ext 32073
Phone Number

TRANSPORTATION BEING PROVIDED (check all that apply)

- Walking - School Bus - Commercial Carrier (bus) - Privately Owned Vehicle

- Leased Vehicle - County Vehicle - None - Other _____
(Describe)

DRIVERS OF PRIVATE OR LEASED VEHICLES (check all that apply)

- Listed Volunteer - Registered Volunteer - Teacher or Staff Member - Other _____
(Describe)

TYPE OF ACTIVITY (Check all that apply)

X - Interscholastic game or competition X - Interscholastic practice(s) - Other _____

Parents should direct questions concerning the athletic activity to the school Athletic Director or the following Coach:

Name _____ Telephone: (321) _____ () _____ - _____
Coach or Sponsor in Charge (School Number) (Mobile Phone)

ALL THE ABOVE TO BE COMPLETED BY THE SCHOOL

PARENTAL AUTHORIZATION AND ACKNOWLEDGEMENT OF RISKS:

1. I understand that participation in athletics' is voluntary, that it is not required, and that it exposes my child to some risk(s).
2. When the school does not provide transportation, the parent or guardian and student are responsible for transportation to and from the off-campus athletic activity.
3. The parent or guardian and student understand that the school district, its officers, agents or employees are not responsible for the student during the time he/she is traveling to or from the off-campus activity, unless the school is providing transportation.
4. The parent or guardian, and student will assume the liability for the student's participation in the off-campus activity and will indemnify and hold the Florida High School Athletic Association and the School Board of Brevard County harmless for any injury or accident or property loss involving the student during the entire course of the extra-curricular athletic activity.
5. Parent or guardian permission for the student to participate in the above activity (ies) may be withdrawn by written notification to the principal or by a change in the student's schedule approved by the principal or designee.
6. I understand that my child will be involved in athletics' off school property: therefore, neither the School Board of Brevard County, or its employees and volunteers, will have any responsibility for the condition or use of any non-school property.
7. I certify that my child is in good health and may participate, but in the event of medical emergency, I/We authorize the coach in charge of the off-campus athletic activity to seek emergency medical treatment for my child at my expense.
8. Some trips may include or have the potential for participation in swimming or other water based activities. Risks and dangers in water may arise from foreseeable or unforeseeable causes. Your signature signifies permission for your child to participate in these activities when supervised by a sponsor(s) and that you will indemnify/hold the School Board of Brevard County harmless for any accident or injury, and hereby assume all risks and dangers and all responsibility for any injury, loss, and/or damage that may occur while your child is engaged in the water related activity (ies).

I/We have read and understand the information above and accept the designated responsibilities. I hereby grant participation in all aspects of this trip - Granted Denied Granted with the following exceptions: _____
(Describe)

Students Signature (Required for All) - Date

Parent/Guardian Signature (Required for all) - Date