

Student Name: _____

Grade: _____

Safety Harbor Middle IB World School
2025-2026 Athletics Participation Checklist

Please staple proof of the following documents and turn into your grade level office before the date of your tryout.

All paperwork must be stapled together and turned in at the same time.

You may also turn in the paperwork packet to your coach on the day of tryouts.

A cumulative 2.0 grade point average (GPA) is required to be eligible to participate.

- Middle School Activities Participation Form
- Preparticipation Physical Evaluation (sports physical)
- Proof of school insurance
 - <https://www.pcsb.org/studentaccidentinsurance>

*Paperwork is valid 365 days from the date issued.

Tryouts:

- Volleyball and Cross-Country tryouts will take place in August
- Basketball and Cheerleading tryouts will take place in October
- Track & Field tryouts will take place in January
- Flag football tryouts take place in March

Disclaimer:

- Safety Harbor Middle IB World School is in a competitive league and playing time for all sports is not guaranteed. It is left to the coach's discretion based on practice and game performance as to how much playing time is garnered by your child.
- The county does not provide buses for away games and all schools rely on parent volunteers for transporting players to away game sites.

Please email Mrs. Tancrell with any questions related to athletics at tancrellk@pcsb.org

GO SEAHAWKS!





PINELLAS COUNTY SCHOOLS
MIDDLE SCHOOL ACTIVITIES PARTICIPATION FORM
HOME EDUCATED STUDENTS MUST BE ASSIGNED TO A SCHOOL THROUGH A FEIC, AND SHOW PROOF OF IMMUNIZATION

*****NOTICE*****

Participation in competitive athletics, including cheerleading, may result in severe injury, including paralysis, or even death! Improvements in equipment, medical treatment and physical conditioning, as well as rule changes, have reduced these risks, but it is impossible to totally eliminate such occurrences from athletics.

Student Information:

Special Programs

NAME AS IT APPEARS ON BIRTH CERTIFICATE

GENDER

GRADE

DATE OF BIRTH

Are you an Administrative Transfer (Check One) ☐ Yes ☐ No Do you have a Special Attendance Permit (Check One) ☐ Yes ☐ No

Residence of Parents or Legal Guardian:

Street Address

City

since

Month

Day

Year

Residence (if Different from Parent(s) or Legal Guardian

Street Address

City

Lived at this address since:

Month

Day

Year

Name(s) and Relationship of Person(s) you Live with if other than parent(s) or legal guardian:

Insurance

Students participating in voluntary extracurricular athletics and activities, as defined by Pinellas County School Board Policy 8760, must purchase the Mandatory Student Accident Insurance made available by the School District. Purchase of a student accident insurance policy for football covers football and all other sports and activities requiring mandatory student accident insurance. Purchase of a (non-football) student accident insurance policy covers all (non-football) school related sports and activities requiring mandatory student accident insurance. Insurance may be purchased on-line at www.pcsb.org under the quick link for student accident insurance. Note: This is excess Insurance. It is provided to cover some of the out-of-pocket expenses associated with accidents. It is not intended to replace your primary medical insurance. Any other medical insurance policy will be expected to pay before this excess student accident insurance policy.

Date Purchased

EMERGENCY MEDICAL TREATMENT PERMISSION AND INFORMATION

I hereby authorize the school to obtain, through a physician of its own choice, any emergency care that may become reasonably necessary for the student listed on this form in the course of athletic activities or travel. Payment of all charges incurred for medical treatment is guaranteed by me or the insurance company providing coverage for the above named student.

1) Allergies and/or special medical problems (list medications carried by student):

2) Date of last Tetanus shot _____ 3) Family Physician _____ Phone _____

Please attach Physical Evaluation Form and any pertinent medical conditions.

Student Participation Permission

*****PARTICIPATION IN COMPETITIVE ATHLETICS CAN RESULT IN SERIOUS INJURY EVEN DEATH. *****

I hereby give my consent for the above named student to represent his/her school in school sponsored athletics and activities. I understand the potential risks and that severe injury, including paralysis, or even death may occur. I hereby agree to waive, release and discharge the School and the Pinellas County School Board from any and all liability for any injury or illness of the above named student (s), including death, or for claims of any nature which may result from participating in voluntary school sponsored extracurricular athletics. I agree to indemnify and hold harmless the School and the Pinellas County School Board from claims of any nature including costs, expenses and fees arising out of or as a result of the participant's actions during this activity. This permission includes team travel for local or out-of-town trips.

STATEMENT:

I do hereby certify that I have read both sides of this form and understand the rules contained herein, and that the information supplied is true and accurate to the best of my knowledge. I understand that this student must continue to reside with me to maintain eligibility. I accept the responsibility to inform the school of any future change of this information.

School Attended last year: _____

Student's Signature

Signature of Parent/ Guardian

Home/work phone

Date

Relationship to the Student

Signature of Parent/ Guardian

Home/work phone

Date

Relationship to the Student

If only one Parent/Guardian signature above, explain reason: _____

Physical Examination (to be completed by physician).

Physical evaluation must be documented on a form provided by the physician or the FHSA.

Please read both pages of this form before returning it to your school or coach.

Parents or Guardians Must Complete This Section

Please read both pages of this form before returning it to your school or coach.

******* NOTICE*******

Participation in competitive athletics, including cheerleading may result in severe injury, including paralysis, or even death! Improvements in equipment, medical treatment and physical conditioning, as well as rule changes, have reduced these risks, but it is impossible to totally eliminate such occurrences from athletics.

Failure to purchase the appropriate student accident insurance policy, or, failure by the Pinellas County School Board to verify that this requirement has been met, does not transfer responsibility for payment of any and all injury related claims and expenses from the student/parent/guardian to the Pinellas County School Board.

Parents and/or Guardians of Prospective Interscholastic Athletes:

Before trying out for an interscholastic sport a student must be certified as eligible, in accordance with the Florida High School Athletic Association rules and the policies of the School Board of Pinellas County.

Parents or Guardians must complete the following sections on the reverse side: Certification of Residency, Permission to Participate/Permission for Emergency Medical Treatment, and Certification of Insurance. Your student will not be allowed to practice until this form is completed and is on file at the school.

The Pinellas County School Board requires students participating in extracurricular activities to purchase the Mandatory Student Accident Insurance (School Board Policy 8760) regardless of your existing insurance coverage.

The following are excerpts of the athletic eligibility rules required by the Florida High School Athletic Association and the School Board of Pinellas County. If further clarification of these rules is required, contact the Assistant Principal at your school. This form is no longer available in three (3) part carbonless sheets; therefore it must be duplicated when completed. The school must keep the original and the parent and coach must have a copy.

PINELLAS COUNTY SCHOOL BOARD POLICY IN BRIEF

*Students must attend the school they are assigned.

*Students whose residences are outside the zone may enroll in a school through the open enrollment process.

*Students who change school assignment between the end of one school year and the beginning of the next school year, are eligible to participate at the newly assigned school provided they are enrolled and attending at the newly assigned school as of the first day of the school year.

*Home educated students must be assigned to a school through the Student Reservation System at any school.

*Students administratively transferred to another regular school for disciplinary reasons shall be ineligible for athletic participation for a period of the remaining of the school year.

*Students returning to any regular school from a successful reassignment/expulsion shall be eligible upon return to any regular school. Students ejected from an athletic contest for unsportsmanlike conduct are subject to a fine to be paid to his/her school. The fine is \$50 or \$250 for gross unsportsmanlike conduct.

ELIGIBILITY REQUIREMENTS

Academic Eligibility

A middle/junior high student must have a 2.0 GPA, or the equivalent of a 2.0 GPA based on a 4.0 scale, at the conclusion of each semester. A student who is academically eligible at the beginning of the semester will continue to be academically eligible for that entire semester. Likewise, a student who is academically ineligible at the beginning of the semester will continue to be academically ineligible for that entire semester, except as provided in Bylaw 9.4.5.1.2 in regards to work not completed due to illness or excused absence.

PLEASE CONTACT YOUR SCHOOLS' ATHLETIC CONTACT IF YOU HAVE QUESTIONS.

* A student may participate one (1) year as a 6th grader, one (1) year as a 7th grader, and one (1) year as an 8th grader.

* A student will be eligible if they are under the age of 15 prior to September 1st .

* Students have four (4) consecutive years of high school eligibility from the date they first enter the 9th grade.

* Physicals are good for 365 days from the date they are given. Once the date has passed the student becomes ineligible.



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 of exam.

EL2

Revised 2/25

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 (continued)		Yes	No
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 of exam.

EL2

Revised 2/25

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

BONE AND JOINT QUESTIONS		Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		

MEDICAL QUESTIONS		Yes	No
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
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?		

MEDICAL QUESTIONS (continued)		Yes	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that you gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

Explain "Yes" answers here:

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 of exam.

EL2

Revised 2/25

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 • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, Ears, Nose, and Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis		
Neurological		

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 • 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 of exam.

EL2

Revised 2/25

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: (____) _____

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.

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction after clearance by medical specialist for: _____

(If this option is checked, additional medical follow-up and clearance prior to sports participation is required. Use EL2 Page 5 for documentation.)

☐ Medically eligible for only certain sports as listed below:

☐ Not medically eligible for any sports

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

In accordance with §1006.20(2)(c), F.S., I hereby certify that I am a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with my regulatory board and 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 #: _____

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



PREPARTICIPATION PHYSICAL EVALUATION (Supplement)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date of exam.

EL2

Revised 2/25

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)*