

# Dunedin Highland Middle School

## ATHLETICS PACKET

*Home of the Highlanders*

Thank you for your interest in participating in our athletic program. Middle school athletics include the following:

1. Volleyball
2. Basketball
3. Track & Field
4. Flag Football

Please complete the checklist below in order to be eligible for each sport at Dunedin Highland Middle School.

- Complete the **Middle School Participation Form**** (attached)
- Purchase the mandatory student accident insurance and provide proof of purchase.**  
<https://www.pcsb.org/studentaccidentinsurance>
- Receive a current sports physical signed by a physician & provide a copy.** Physicals are good for up to a year after the date they are given. If you need a form, the Florida High School Athletics Association (FHSA) form is attached.
- Meet academic eligibility** by having a 2.0 GPA from the previous semester.
  - For Volleyball and Basketball:
    - 7<sup>th</sup> & 8<sup>th</sup> grade athletes: Eligibility is based on 2021-2022 Spring semester GPA.
    - 6<sup>th</sup> grade athletes: Automatically eligible for first semester sports.
  - For Track and Flag Football:
    - Eligibility will be based on 2022-2023 1<sup>st</sup> semester GPA.





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.

Parents or Guardians Must Complete This Section

**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:** \_\_\_\_\_ since \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Street Address City 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](http://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.

	<b>School Attended last year:</b> _____
<small>Student's Signature</small>	
<small>Signature of Parent/ Guardian</small>	<small>Home/work phone</small>
<small>Signature of Parent/ Guardian</small>	<small>Date</small>
<small>Signature of Parent/ Guardian</small>	<small>Relationship to the Student</small>
<small>Signature of Parent/ Guardian</small>	<small>Relationship to the Student</small>

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 FHSAA.

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

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



Preparticipation Physical Evaluation (Page 2 of 3)

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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

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 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: \_\_\_\_\_



# Preparticipation Physical Evaluation (Page 3 of 3)

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Student's Name: \_\_\_\_\_

**ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)**

I hereby certify that the examination(s) for which referred was/were 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: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician (print): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

*Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.*