2015-2016

HEALTH SERVICES FORMS

PLEASE SUBMIT BACK TO IMG ACADEMY BY AUGUST 1, 2015

IMG ACADEMY

TABLE OF CONTENTS AND CHECKLIST

In order to complete the Academy Program enrollment process and confirm your space at IMG Academy, all forms must be completed, signed and returned. Many forms require a signature from both the parent/guardian and participant.

PLEASE USE THE TABLE OF CONTENTS AS A CHECKLIST TO ENSURE ALL FORMS ARE COMPLETED AND RETURNED BY AUGUST 1, 2015.

In order to be eligible for participation in teams for schools that belong to the Florida High School Athletic Association (FHSAA), they require that the Preparticipation Physical Evaluation form be completed. The FHSAA is willing to accept the IMG Physician form as an acceptable substitute as long as the participant's parents have completed and signed page 1 of the FH-SAA form. If your child does not have this health history portion satisfactorily completed, they will not be able to participate in those teams. PLEASE COMPLETE, SIGN AND SUBMIT THIS FORM ALONG WITH THE COMPLETED IMG PHYSICIAN FORM.

STUDENT HEALTH RECORDS

PLEASE NOTE: THIS FORM SHOULD BE COMPLETED IN ENGLISH. THE STUDENT HEALTH RECORDS/PHYSICIAN'S REPORT FORMS ARE DUE ANNUALLY. THIS PAGE IS TO BE COMPLETED BY THE PARENT/GUARDIAN.

First Name: _____ Last Name: _____ Date of Birth _____
MM/DD/YYYY

Gender: ☐ Male ☐ Female Housing: ☐ Boarding ☐ Non-boarding Sport(s): _____

Camper Allergy Information: Does student have any known allergies to food/medicine/other? ☐ No ☐Yes (If so, please mark allergies below):

☐ Penicillin ☐ Aspirin ☐ Peanuts ☐ Bees ☐ Eggs ☐ Dairy ☐ Soy ☐ Tree nuts ☐ Shellfish ☐Other: _____

What treatment or medication is to be given in the event your student has an allergic reaction?: _____

Does your child carry an Epi-Pen? ☐ No ☐ Yes (Please check-in with Health Services upon arrival to pick up an epi-pen luggage tag)

HEALTH HISTORY:

***** If your student has a chronic medical condition such as diabetes, seizure disorder, hemophilia, severe allergies or mental health disorder, there might be special requirements that are applicable for your child to attend or to board at IMG Academy. Please contact Health Services at 941-752-2479 to discuss these requirements prior to enrolling or making any travel arrangements to IMG Academy. In some instances, the child may be required to be a non-boarding student to participate in our programs.*****

01	Diabetes Type: _____	Date: _____	☐ Yes	☐ No
02	Asthma/Bronchitis Comments: _____	Date: _____	☐ Yes	☐ No
03	Does the student cough, wheeze, or have trouble breathing during or after activity?	Date: _____	☐ Yes	☐ No
04	Epilepsy/Seizure Disorder Comments: _____	Date: _____	☐ Yes	☐ No
05	Has the student ever had a diagnosed concussion?	Date: _____	☐ Yes	☐ No
	a. If YES, how many? _____			
	b. Within last 6 months, provide documentation of event and include doctor's clearance.			
06	Has the student ever experienced unconsciousness, memory loss or had a seizure as a result of a head injury?	Date: _____	☐ Yes	☐ No
07	Mononucleosis Comments: _____	Date: _____	☐ Yes	☐ No
08	Has the student or any family member ever had an adverse reaction to anesthesia (ex. malignant hyperthermia)?	Date: _____	☐ Yes	☐ No
09	Does the student have a history of or currently have an eating disorder?	Date: _____	☐ Yes	☐ No
10	Does the student have a history of or currently have any mental health issues (ex. depression, anxiety, stress, ADD/ADHD)?	Date: _____	☐ Yes	☐ No
	a. Does the student take medication related to a mental health issue? (ex. anti-depressant, anti-anxiety, ADD/ADHD medications)?	Date: _____	☐ Yes	☐ No
	b. If YES, what medications? _____			
11	Has the student ever been referred/evaluated by a psychiatrist/psychologist?	Date: _____	☐ Yes	☐ No
12	Pneumonia Comments: _____	Date: _____	☐ Yes	☐ No
13	Sinusitis Comments: _____	Date: _____	☐ Yes	☐ No
14	Tonsillitis Comments: _____	Date: _____	☐ Yes	☐ No
15	Does the student have painful menstrual cycles? How is it treated? _____		☐ Yes	☐ No
16	Does the student have any current skin problems (ex. itching, rashes, acne, warts, fungus)?	Date: _____	☐ Yes	☐ No
17	Does the student have frequent or severe headaches or migraines?	Date: _____	☐ Yes	☐ No
18	Has the student ever had numbness or tingling in their arms, hands, legs, or feet?	Date: _____	☐ Yes	☐ No

Explain "YES" Answers: _____

STUDENT HEALTH RECORDS

Name of Participant : _____

THIS PAGE IS TO BE COMPLETED BY THE PARENT/GUARDIAN

List any surgeries or hospitalizations:

DATE	SURGERY	HOSPITALIZATION

CURRENT MEDICATIONS:

Please list all medications and their dosages (including over-the-counter medications and supplements) that your child is taking:

MEDICATION	DOSAGE	INSTRUCTIONS

MEDICATION REQUIREMENTS:

1. For the safety of all of our students, medication is not allowed to be in a student's room.
2. No medical planners (weekly pill dispensers) are allowed.
3. All prescription medications must have an official pharmacy label attached to the bottle/package (in English) which includes the child's name, instructions, etc. -OR- must be in its original package and accompanied by a doctor's written orders for administration (in English).

   Note: Prescription medications will be dispensed according to the pharmacy label or the doctor's written orders only. Any changes to the dosage amount, frequency, etc. need to have a new doctor's written order stating how it should be given.
4. All over-the-counter medications must be in their original bottle/package (in English). A parent may include specific instructions regarding how much, how often and what time your child should take it. Otherwise, it will be dispensed when your child asks for it (as needed – and per package instructions).

ORTHOPEDIC HISTORY

Please provide any previous injuries your student has suffered: Include dates, surgeries, special tests (CAT scan, x-ray, MRI, etc), right or left body part.

Head (Including ear, teeth, nose, and eyes):		Wrists:	
Neck:		Hands/Fingers:	
Back:		Thighs:	
Chest:		Knee:	
Shoulders:		Lower Leg (shin/calves):	
Arms:		Ankles:	
Elbows:		Feet/Toes:	

Is there anything else we should be aware of regarding your student's health?

_____

_____

_____

I hereby state, to the best of my knowledge, my answers to the above questions are complete and correct. I understand and acknowledge that I am hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECHO) and/or cardio stress test. If any of the above tests are performed on your student, please include a copy with this form.

_____ _____

Signature of Parent / Guardian — Date of Completion (MM/DD/YYYY)

_____

Please print name

PHYSICIAN'S REPORT

Name of Participant : _____

PHYSICIAN'S REPORT - MUST BE COMPLETED BY PHYSICIAN IN ENGLISH AND ON IMG PAPERWORK.
Based upon Florida statutes, any health professional who is licensed in Florida or the state/country the student resided in at the time of the health examination and who is authorized to perform a general health examination under such licensure shall be acceptable to complete the Physician's Report. A health professional includes an individual who is a licensed M.D., D.O., Physician's Assistant/P.A., or Nurse Practitioner/ARNP.

RECENT ORTHOPEDIC HISTORY (required)

1. Has the student had any orthopedic injuries within the last six months? ☐ Yes ☐ No Date: _____
   a. If YES, please specify the injury: _____
   b. If YES, does the student have clearance to resume participation in sport in returning from the injury? ☐ Yes ☐ No

RECENT CONCUSSION HISTORY (required)

1. Has the student had a diagnosed concussion within the last six months? ☐ Yes ☐ No Date: _____
   a. If YES, does the student have clearance to resume participation in sport in returning from the concussion? ☐ Yes ☐ No

PHYSICAL EXAM

Describe any variations from the norm N = Normal Ab = Abnormal

Teeth:	Scalp:	GI System:
Glands:	Extremities:	Vital Signs:
Lungs:	Eyes:	Menses:
Skin:	Ears:	Chest X-Ray:
Heart:	Abdomen:	Other:
Abnormal explained:		

SCREENING TESTS

Height:	Weight:		BP:	P:
Vision Distance Acuity:	Right _____	Left _____	With Correction	Wears Glasses ☐ Yes ☐ No
	Right _____	Left _____	Without Correction	Wears Contacts ☐ Yes ☐ No

TUBERCULOSIS SCREENING (MANTOUX PPD SKIN TEST)

Have you been experiencing any of the following signs and symptoms that may be associated with tuberculosis?
(Anyone with a "Yes" response will require a TB test or chest x-ray)

1. Persistent Cough (>3 weeks)	☐ Yes	☐ No	6. Night Sweats	☐ Yes	☐ No
2. Coughing up Blood	☐ Yes	☐ No	7. Tire Easily	☐ Yes	☐ No
3. Unexplained Weight Loss	☐ Yes	☐ No	8. Have you ever had a positive TB skin test?	☐ Yes	☐ No
4. Loss of Appetite	☐ Yes	☐ No	9. Have you ever taken prophylactic medication because you were exposed to TB?	☐ Yes	☐ No
5. Fever/Chills	☐ Yes	☐ No			

Date of Test:	Date Read:	2nd Test Required: ☐ Yes ☐ No
Site:	Results in MM:	Date of 2nd Test:
By:	By:	Site:
Manufacturer:		By:
Lot #:	Results in MM:	Expiration Date:

PHYSICIAN'S REPORT

Name of Student : _____

PHYSICIAN'S REPORT - MUST BE COMPLETED BY PHYSICIAN IN ENGLISH

12 POINT CARDIAC EVALUATION

IMG Academy is dedicated to the health and safety of our athletes. For that reason we have adopted the American Heart Association's 12 Point Recommendations for Pre-Participation Screening. **Any "yes" answers need to result in: (1) ECG (2) echocardiogram (3) letter of clearance from a cardiologist to be delivered prior to student's travel to IMG.** *Personal Medical History and Family Medical History sections may be completed by a parent/guardian.*

PERSONAL MEDICAL HISTORY (Please see above for any "Yes" response)			**COMMENTS**
Exertional chest pain/discomfort	☐ Yes	☐ No	
Syncope/near syncope	☐ Yes	☐ No	
Excessive exertional and otherwise unexplained dyspnea/fatigue associated with exercise	☐ Yes	☐ No	
Prior recognition of heart murmur	☐ Yes	☐ No	
Elevated blood pressure	☐ Yes	☐ No	

FAMILY MEDICAL HISTORY (Please see above for any "Yes" response)			**COMMENTS**
Premature death (sudden or otherwise) related to heart disease in relatives younger than 50 years	☐ Yes	☐ No	
Disability from heart disease in close relative younger than 50 years	☐ Yes	☐ No	
Specific knowledge of hypertrophic or dilated cardiomyopathy, ion channelopathies such as long QT syndrome, Marfan Syndrome, or clinically important arrhythmias	☐ Yes	☐ No	

PHYSICAL EXAMINATION (Must be completed by a health professional - Please see above for any "Yes" response)			**COMMENTS**
Heart murmur	☐ Yes	☐ No	
Aortic Coarctation noted on Femoral Pulse Exam	☐ Yes	☐ No	
Physical stigmata of Marfan syndrome	☐ Yes	☐ No	
Abnormal Brachial artery blood pressure (sitting position)	☐ Yes	☐ No	

Notes: _____

Additional information the examiner believes should be brought to the attention of IMG Academy to enable the student to participate in athletics or to provide for student's well being: _____

_____

I understand that IMG Academy programs may include vigorous physical activities and exertion, which can occur in a hot and humid environment, such as Bradenton, Florida. I have discussed **both page 4 and page 5**, including the "12 Point Cardiac Evaluation," with the student and parents, performed a physical examination and believe he/she is physically able to participate in athletic and sports activities as described with unrestricted clearance.

Physician's Name (Print): _____

Physician's Signature: _____

Address: _____ Date: MM/DD/YYYY

City, State, Zip: _____

Phone: ( ) _____ Fax: ( ) _____

IMMUNIZATION RECORD

MUST BE COMPLETED IN ENGLISH. NEW STUDENTS COMPLETE IN FULL. RETURNING STUDENTS SUBMIT UPDATES ONLY.

NAME OF PARTICIPANT: _____ **DATE OF BIRTH:** _____

IMMUNIZATIONS	DATES RECEIVED (MM/DD/YYYY)				
DPT (diptheria, tetanus, pertussis) or TD (tetanus, diptheria) or DTP-Hib (5 required)					
Td (Tetanus)					
Polio: OPV, IPV (4th dose required if 3rd given before age 4)					
MMR (Mumps, Measles, Rubella) 2 doses required					
Hepatitis B (Series of 3 required)					
Varicella (Chicken Pox) required unless documented history of disease	Vaccine:	Vaccine:	Disease:		
Meningococcal					

2015-2016 SCHOOL ENTRY REQUIREMENTS

Prior to entry, attendance, or transfer to a Florida school (kindergarten through 12 grade) each child should have a completed Florida Certification of Immunization (schedule below), documenting the following:

— Four or five doses of diphtheria-tetanus-pertussis (DTaP) vaccine
— Two or three doses of hepatitis B (hep B) vaccine
— Four or five doses of polio vaccine*
— Two doses of measles-mumps-rubella (MMR) vaccine
— Two doses of varicella vaccine+ for kindergarten and grades one and two
— One dose of varicella vaccine+ for grades three through nine

* If fourth dose of vaccine is administered prior to the fourth birthday, a fifth dose of polio vaccine is required for entry into kindergarten.

+Varicella vaccine is not required if varicella disease is documented by the healthcare provider.

For more information, call (850)245-4342 or visit WWW.IMMUNIZEFLORIDA.ORG

MENINGOCOCCAL VACCINE

I understand that the Meningococcal (Meningitis) vaccine is strongly recommended by the US Centers for Disease Control (CDC) for students.

☐ I wish to decline the Meningococcal vaccine for my student. I understand and accept the risks of my student not having this vaccine which can cause very severe illness and death.

☐ I will take my student to his/her local physician or Health Department to obtain the Meningococcal vaccine, and I will provide IMG Academy with proof of vaccination.

☐ My student has already received the Meningococcal vaccine, and the date is recorded above.

_____ _____
Signature of Person completing immunization record Date of Completion

_____
Please print name

HEALTH CARE POLICIES

NAME OF PARTICIPANT: _____

The Health Services Department is available 7 days per week in an effort to make available high quality health care services for your child. The scope of services IMG Academy Health Services staff provide differs somewhat between those boarding and those non-boarding (see chart below).

HEALTH CARE SERVICES PROVIDED	BOARDING	NON-BOARDING
Emergency Care	X	X
Basic First Aid during school or program hours	X	Sick child must be picked up by parent/authorized adult within an hour of our notification
Follow-up/monitoring outside of school hours	X	
Coordination of doctor appointments	X	
Administration of prescription medications	X	Emergency cases only (i.e. EpiPen)
Administration of Over The Counter medications	X	Requires parental approval at time of need

ADDITIONAL INFORMATION FOR BOARDING STUDENTS:

A. Doctor Visits: From time to time independent medical, dental, or mental health practitioners make their services available on-campus ("On-campus Independent Practitioners"). IMG Academy does not endorse the use of any particular On-campus Independent Practitioners and students may be seen by any practitioner with whom the student's parents make arrangement. If your child sees other providers off campus, 72 hours advance notice is requested and transportation fees will apply.

B. Transportation Fees: Transportation is available from IMGA to off-campus doctor's offices upon request. The cost is $50 for the first hour and $25 for each additional hour. The doctor's visit is calculated in the time. The total charge for round-trip transport will not exceed $100.

C. Observation: Health Services will provide short-term observation when a child is ill. Parents of boarding students will be required to care for their child if surgery is deemed necessary or if long-term observation, isolation or rehabilitation is required or the student needs to return home for such treatment, isolation or rehabilitation.

D. Medications: Please read and complete the Boarding Students Consent for Medication and Boarding Students Medication Policy. These forms must be completed for boarding students even if your child is not currently taking medications.

GUIDELINES FOR FOOD ALLERGY MANAGEMENT

- IMG Academy does not knowingly incorporate peanuts or tree nuts into foods served in the cafeteria, clubhouse, and bistro. However, IMG Academy cannot prevent all cross-contamination during food manufacturing, transportation and service process. Please be advised that IMG Academy Golf and Country Club does incorporate nuts into its menu. The Country Club is not located on the main campus of IMG Academy.
- IMG Academy will designate and clean a table in the junior cafeteria for use by food allergy sufferers.
- Parents of participants with severe allergies and other potentially life-threatening medical conditions may elect to have their personal information listed on a separate medical identification card which should be carried by the student at all time with their student identification card.
- To the extent reasonably available, students with food allergies will have the opportunity to purchase individually sealed meals that are free of specific allergens. To participate, students must make arrangements with the Food and Beverage department by calling 941-752-2491.

REMEMBER: Parents/Guardians should inform participant who suffers from severe allergies, food or otherwise to:

- Notify the IMG Academy Health Services Department of their allergies and prescribed treatments before arrival on campus.
- Consult with their private health care practitioners regarding appropriate management of their allergies and be prepared to manage their allergic conditions before arrival on campus. Students should carry their EpiPen or other treatment with them as prescribed by their physician.
- Be aware of the possibility of exposures at anytime and NEVER trade food with others.
- Always seek treatment for any reactions or possible exposure. All questions about the policy or a specific allergy issue should be addressed with IMG Academy Health Services at (941) 752-2479 or email healthservices@img.com.

My signature below confirms that I have read and understand the above policies.

_____ _____

Signature of Parent/Guardian Date

CONSENT FOR MEDICATION

(BOARDING STUDENTS ONLY)

This form is required for all boarding students, even if they are not currently taking any Medication.

NAME OF PARTICIPANT: _____

(Please Print Name)

Parents and students are required to provide IMG Academy with a list of all medications that are currently used by the student. This information should be provided in the spaces below. In accordance with IMG policy, students may self-administer the following medication with parental/guardian permission. IMG Academy reserves the right to revoke a student's right to self administer medication when, in the professional judgment of IMG Academy Health Services staff, the student has demonstrated an inability to self medicate safely.

Permitted Medications:
Topical creams and cleansers, eye drops, inhalers, nasal sprays, oral contraceptives, epi-pens, and over the counter (OTC) medications.

Medication Consent for Self Administration:

Would you like your student to be able to store and self administer Permitted Medications? ☐ Yes ☐ No

In the event my student takes an off campus trip, I give consent to IMG Academy to dispense my student's prescribed medications to them for self administration. ☐ Yes ☐ No

Medication Compliance:

Health Services expects the student to report regularly for prescription medication at designated times. If a student fails to comply with these guidelines, a parent will be notified in the presence of the student.

_____ _____

Signature of Participant Date

_____ _____

Printed Name of Parent / Guardian Date

_____

Signature of Parent / Guardian

CONSENT FOR TREATMENT

This is to certify that the staff of IMG Academy LLC is being given authority by me, the custodial parent:

_____ ☐ Parent or ☐ Guardian of _____

(Please Print Parent/Guardian Name) (Name of Participant)

to act on my behalf for any medical/mental health care treatment (including immunizations) and prescriptions reasonably necessary or medically advisable to maintain the life, health and well-being of my child. This includes, but is not limited to, first aid care and prevention of injuries, mental health interventions, follow-up care and the taking of over-the-counter or prescription medicines that are approved by a physician even when the child is not seen by a physician. This consent for treatment extends to the signing and conduct of: (1) legal authorization for treatment; (2) consultations; (3) anesthesia; (4) emergency examinations; (5) consent for hospitalization; (6) mental health treatment, (7) treatment or surgery that may be deemed necessary by appropriate medical personnel and (8) disclosure of all medical information, electronically, orally or in print, related to any treatment.

DRUG AND ALCOHOL TESTING AUTHORIZATION

The use of illegal drugs, controlled substances and alcohol can have a detrimental impact on behavior, interfere with academic and athletic performance, cause permanent physical and mental harm to the user and increase the risk of injury to teammates, athletic opponents and all others with whom the user interacts. Therefore, IMG Academy LLC has implemented a Drug and Alcohol Testing Policy ("Policy") that is described in the Student Handbook. All parties signing this form acknowledge that they have received, read and understand the Policy, and also understand that penalties may be imposed, including expulsion, for violating the Policy. Further, all parties signing this form agree to all of the terms, conditions and rules of the Policy.

A participant who is age 13 and older will be subject to mandatory testing during the school year. Reasonable suspicion testing may be conducted for all participants regardless of age. Each test will consist of hair analysis, urine analysis or other method adopted by IMG.

I hereby consent to having samples of my student's hair, urine or other body sample tested for the presence of drugs, alcohol or other substances covered by the Policy at such times as tests are required under the Policy. I also authorize the release of information concerning the results of such test to the Participant and IMG Academy.

MEDICAL IDENTIFICATION CARD

I voluntarily wish to add the following information regarding severe allergies, chronic illnesses or other potentially life threatening medical conditions to my child's campus identification. I further consent to this information being posted on my child's student records and files. I understand that this information is shared among IMG Academy' employees, in print and electronically:

_____

_____

_____

AUTHORIZATION FOR ALL PURPOSES

My signature below gives my permission for the above that includes Consent for Treatment, Drug and Alcohol Testing, Medical Identification Card and use of my credit card as needed for medical treatment:

_____	_____	_____
Participant Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date

EMERGENCY CONTACT

NAME OF PARTICIPANT: _____

PLEASE COMPLETE IN ENGLISH. PLEASE MAKE SURE TO PROVIDE YOUR SIGNATURE AND DATE AT THE BOTTOM OF THIS PAGE.
With the safety and well-being of your child in mind, we are asking that you provide three emergency contacts. We will only call the second and third person if we are unable to reach the first on the list. These three (3) contacts should be listed below in the order in which you would like them called. If the parent/legal guardian would like to be the first person called in case of an emergency, please be sure to list yourself as Emergency Contact #1. If possible, please be certain that at least one of the contacts is able to communicate in English.

Please list phone numbers below in order they should be called: If international please include country and city codes.

Emergency Contact #1

Name of Contact: _____ Relationship to student: _____

Language: _____ Country to be called: _____

English Speaker: ☐ Yes ☐ No Email: _____

1. _____ # Type: _____

2. _____ # Type: _____

3. _____ # Type: _____

(Contact Numbers) (Specify home, cell or business)

Emergency Contact #2

Name of Contact: _____ Relationship to student: _____

Language: _____ Country to be called: _____

English Speaker: ☐ Yes ☐ No Email: _____

1. _____ # Type: _____

2. _____ # Type: _____

3. _____ # Type: _____

(Contact Numbers) (Specify home, cell or business)

Emergency Contact #3

Name of Contact: _____ Relationship to student: _____

Language: _____ Country to be called: _____

English Speaker: ☐ Yes ☐ No Email: _____

1. _____ # Type: _____

2. _____ # Type: _____

3. _____ # Type: _____

(Contact Numbers) (Specify home, cell or business)

Should this contact information change during the school year, it is the responsibility of the family to notify us with these changes.

Signature of Custodial Parent: _____ **Date**: _____
MM/DD/YYYY

HEALTH INSURANCE REQUIREMENTS

Name of Participant : _____

Boarding _____ Non-boarding _____

☐ Male or ☐ Female Date of Birth _____ Sport _____ Home Country _____
MM/DD/YYYY

HEALTH INSURANCE REQUIREMENTS/MEDICAL ACCOUNT DEPOSIT

Out of concern for the health and welfare of our students, IMG Academy ("IMGA") requires that every Academy Program student be covered by a United States based comprehensive injury and sickness plan that will meet the high cost of medical services and is accepted by local medical providers should your child need medical attention.

Please note that this means that no international insurances, travel insurances or credit card reimbursement plans for medical expenses will be accepted for the school year as acceptable health insurance coverage by IMGA. USA based Medicaid and HMO plans not issued in the State of Florida will not be accepted by IMGA for boarding students. This is a mandatory requirement of the registration process. Your child will not receive a permanent ID when arriving to campus until after your child provides proof of insurance coverage meeting these requirements. Without a permanent ID, your child will not be able to participate in sport and academic programs.

To meet your injury and sickness plan coverage responsibilities for your child, you may have or arrange for private US based health insurance coverage for your child. Alternatively, if you do not have US-based private health insurance coverage that meets the IMGA requirements, you can choose to enroll your child in the comprehensive injury and sickness plan described below which is offered through Clifford Allen Associates as agent for United HealthCare® Services, Inc. ("United Healthcare®") - a health care company located in Salt Lake City, Utah (the "UHC Plan"):

The UHC Plan (Primary Coverage): The UHC Plan provides you with primary, first dollar benefits for approved health care claims. The UHC Plan will cover your child during a semester or 10-month period for an annual premium (the "Premium"). The UHC Plan was designed by United Healthcare® (and not IMGA) for the students at IMGA as stated in the enclosed brochure. Please note that the UHC Plan is offered directly by Clifford Allen Associates for United Healthcare® and not by IMGA to you. Please read the enclosed plan brochure carefully for a description of the UHC Plan insurance coverage, limits and exclusions.

Medical Account Deposit: Each boarding student is required to set up a medical account at IMGA at registration/check-in to help fund your private health insurance or UHC Plan deductibles, co-pays or fees for services not covered under your health plan. The amount to be paid into this medical account must be a minimum of $300.00. If this medical account money is not used during the year, it will be returned to you at the end of the year. If the amount is used during the year, you agree to replace the monies necessary to fund your child's medical account with the required minimum amount.

YOU MUST SELECT ONE OF THE TWO OPTIONS PROVIDED BELOW:

2014-2015 United Health Care Student Injury & Sickness Plan

☐ YES* - Enroll my child in the UHC Plan for (select one option):

☐ **1st Semester**	☐ **2nd Semester**	☐ **10-Month**
8/15/2015 through 1/15/2016	1/16/2016 through 6/15/2016	8/15/2015 through 6/15/2016
Premium Cost: $1200	Premium Cost: $1395	Premium Cost: $2595

I have received a copy of the United Healthcare Student Insurance brochure and understand the insurance limits and exclusions. I understand that I am financially responsible for co-pays, coinsurances or medical services not covered under this plan. *If you choose to enroll your child in the UHC Plan, the Premium is due in full at the time of registration/check-in at IMGA. You may also remit payment prior to arrival by providing a credit card number below or sending a check made out to IMG Academy LLP.

_____ _____ _____
Parent/Guardian Signature | Printed Name | Date

SELECT PAYMENT OPTION: ☐ **Wire Transfer** ☐ **Credit Card on File Ending in:** _____ (Last 4 Digits) ☐ **Included in Tuition Enrollment Agreement (TEA)**

☐ NO**- Do not enroll my child in the UHC Plan. My child is enrolled in a US based private health insurance plan that meets IMGA requirements. I understand that I am financially responsible for all deductibles, co-pays, coinsurances or medical services not covered by my plan.

<u>If you choose this option, then you must provide an enlarged, clear copy of both sides of the insurance card evidencing your private health insurance coverage for your child.</u>** Please include the policy holder's name and policy holder's date of birth. The requirement will not be fulfilled until you provide this information and it has been accepted by IMGA.

_____ _____ _____
Parent/Guardian Signature | Printed Name | Date

_____ _____
Insurance Policy Holder Name | Policy Holder Date of Birth

If you have any questions regarding this requirement, please contact Insurance CoordinatorErika Rivera at (941) 752-2616. Please complete this form and return it to the IMG Academy Health Services Office by August 1 if you are applying for the Fall semester or December 1 if applying for the Spring semester. If you are choosing not to enroll your student please attach all of your insurance information as requested. You may return this information along with your enrollment packet or fax to (941) 752-2630.

* *Information sheet with plan details on following page <<*

2015-2016 STUDENT INSURANCE PLAN

Plan Summary – Key Components

IN NETWORK

Using providers who participate in the United Health Care network – please visit www.myuhc.com – select options PPO network for a list of providers

- Zero deductible
- Pre-existing conditions are covered from day one
- 100% to $250,000 maximum benefit for each injury and sickness
- Surgery paid at 100% of agreed to fee
- Hospital room and board paid – including intensive care
- Interscholastic sport's related injuries covered to $250,000
- Prescription drugs covered at 100% up to $2,000 annually
- Preventive care included
- Doctor's visits covered at 100% of agreed to fee
- Out-patient psych (including prescription drugs) treated as any other illness
- Outpatient physiotherapy covered at 100%. Review of Medical Necessity will be performed after 12 visits per injury/sickness.
- Acne treatment covered under prescription drug benefit
- Allergy treatment (not testing) covered under prescription drug benefit
- Lab tests and x-rays covered under out-patient benefit at 100%
- Treatment of injury to sound natural teeth covered – no separate limit
- Braces and appliances paid at 100% of agreed to fee (not applicable to teeth)
- Repatriation and medical evacuation benefits provided – no maximum limit
- Your child is covered anywhere, including your home country

OUT OF NETWORK

Using providers not in the United Health Care network

- Zero deductible
- Pre-existing conditions are covered from day one
- 80% to $250,000 maximum benefit for each injury or sickness
- Surgery paid at 80% of usual and customary charges
- Hospital room and board paid at 80% of usual and customary charges
- Interscholastic sport's related injuries covered to $500,000
- Prescription drugs covered at 80%
- Preventive care included
- Doctor's visits covered at 80% of usual and customary charges
- Out-patient psych (including prescription drugs) treated as any other illness
- Outpatient physiotherapy covered at 80% up to $2,500 per policy year
- Acne treatment covered under prescription drug benefit
- Allergy treatment (not testing) covered under prescription drug benefit
- Lab tests and x-rays covered under out-patient benefit at 80%
- Treatment of injury to sound natural teeth covered – no separate limit
- Braces and appliances paid at 80% of U&C (not applicable to teeth)
- Repatriation and medical evacuation benefits provided – no maximum limit
- Your child is covered anywhere, including your home country

POLICY EXCLUSIONS

- Services and supplies not medically necessary
- Cosmetic surgery, except to correct a covered injury
- Dental treatment, except as specified above
- Loss due to war, declared/undeclared, service in armed forces in any country
- Eye glasses, hearing aids and exams for the prescription or fitting thereof
- Expenses incurred from the use of alcohol or intoxicants
- Payment of drugs unless prescribed by a physician
- Flight in any aircraft except as a passenger on a commercial airline flight
- Experimental services or supplies, including treatment, procedure, drugs or devices not recognized as acceptable medical practice

This is only a partial outline of benefits and exclusions as underwritten. By the united health care insurance company and serviced by clifford allen associates, ltd. Certificates will be issued containing an in-depth explanation.

IMG ACADEMY STUDENT-ATHLETE SUPPLEMENT POLICY FAQ

1. Why does IMG Academy have a permissible supplement list?
a. To permit supplement use on campus in a safe manner. Supplements are not regulated and may contain contaminated substances that cause a positive-drug test and jeopardize potential for athletic eligibility and scholarship.

2. How do I find out if a supplement I am using or would like to use is permitted for use at IMG Academy?
a. Permissible list available on Current Students & Parents page of IMGAcademy.com

3. What supplements are permitted on campus without a physician prescription?
a. Multivitamin
b. Sport drinks and recovery protein

4. For the permissible supplements that do require a physician prescription, what is the reason for requiring a prescription since these are available over the counter?
a. Although these products are available over the counter, a prescription is required for 3 reasons:
1) To ensure proper dose and use of the supplement.
2) With a prescription, it can be reimbursed through insurance.
3) This procedure is consistent with athlete prescriptions at the university level.

5. How often do I need to renew my physician prescription, if required?
a. Each year with the registration packet.

6. What if a supplement I would like to use is not on the permissible supplement list?
a. It is not permitted on campus.

7. What steps do I need to take in order to have a supplement on campus?
1st: **PERMISSIBLE LIST**: Check to see if the supplement is on the permissible supplement list
i. Permissible list available on Current Students & Parents page of IMGAcademy.com
2nd: **WAIVER FORM**: At initial registration, have your parent or guardian complete the waiver permitting the supplement to be on campus, which will be returned to Health Services.
i. If over 18 years old, athlete may sign his/her own waiver.
ii. The waiver is found in the "IMG Academy Registration & Academic Forms Packet."
3rd: **PRESCRIPTION**: Determine if the supplement requires a physician prescription.
i. List of supplements that do not require a physician prescription available on Current Students & Parents page of IMGAcademy.com
ii. List of supplements that do require a prescription from a physician available on Current Students & Parents page of IMGAcademy.com
4th: **PURCHASE**: Responsibility of the student to purchase through desired vendor.
5th: **PRODUCT VERIFICATION**: Verification from Health Services.
i. Take product to Health Services for verification. Verification will not be provided if Steps 1, 2, 3, & 4 have not been completed.
ii. Health Services will provide verification for the product to be permitted in the student's room.
iii. **Supplement will be discarded if the product has not been verified.**

8. How often do I need to get my guardian/parent waiver form signed?
a. Each year with the registration packet.

9. What do I do if I have a supplement removed from my room?
a. All removed supplements by Student Services will be discarded within 24 hours & parents/guardians will be informed.

10. Can my parent or guardian give me permission to take a supplement that is not on the permissible list?
a. No.

11. If I am over 18 years of age, do I need parent or guardian permission to take a supplement?
a. No.

12. Can I consume any supplements that contain caffeine?
a. In our effort to be in compliance with NCAA and WADA policies, stimulants or supplements containing stimulants are not permitted on campus. Caffeine is a stimulant and therefore not permitted in supplements on campus.

13. Is it possible to have a supplement from another country permitted for consumption?
a. Only supplements on the permissible list may be on campus.

14. How can I get more information regarding whether the effective use of supplements is something I should consider?
a. Nutrition consult (Contact us at 941-752-2648 to sign up for a consult)

IMG ACADEMY STUDENT-ATHLETE SUPPLEMENT POLICY AND CONSENT FORM

IMG Academy supports the use of food as the best choice for optimal sports nutrition performance. We recognize, however, that some sport supplements may be beneficial for overall health and/or performance.

A. For the purposes of this policy, "Supplement" means any product (pill, tablet, soft chew, powder, liquid, beverage, etc.) designed to augment the diet and includes one or more of the following ingredients: vitamins, minerals, herbs, botanicals, amino acids, ergogenic aids, calorie boosters, concentrate, metabolite, constituent, extract, or combination of these ingredients. The Permissible List of Supplements is available on the Current Students & Parents page on IMGAcademy.com, and a Supplement on this list is a "Permissible Supplement".

B. For the purposes of this policy, a "Student-Athlete" means an athlete enrolled in IMG Academy school or sport who trains at the IMG Academy campus and who may wish to use Permissible Supplements on the Academy Campus.

C. Student-Athletes at IMG Academy are permitted to use Permissible Supplements with approval as outlined below:
1. **Legal Guardians.** Legal guardians must provide documentation to permit the Student-Athlete to have a Permissible Supplement on campus in their possession in the following Supplement: Multivitamins and Proteins.
2. **Physician Prescriptions.** All other Permissible Supplements require a physician prescription in English with original, cursive signature and dated. The prescription must include the following: Type of Supplement, Brand and Dose. All prescriptions must be renewed annually.

D. Currently, only Gatorade sports drinks or recover shakes are offered by IMG Academy to Student-Athletes, which is consistent with NCAA guidelines.

E. Some Supplements have been found to be contaminated, which may result in a positive drug test. Supplements on the IMG Academy Permissible List are certified to be free of banned substances from a third-party testing organization, such as NSF International, Banned Substance Control Group (BSCG), and/or Informed-Choice.

F. No Supplement is a substitute for optimal nutrition, physical, and mental conditioning. Therefore it is recommended to evaluate or re-evaluate Supplements, current eating plan, and strategies to optimize performance with an individual nutrition consult.

G. Each Student-Athlete is fully responsible for the Supplements he or she consumes, any side effects that may occur, and any consequences that may arise from the use of the Supplements, including, without limitation, loss of eligibility, or sanctions from any organization.

H. Students will submit the guardian permissions and physician prescriptions to Health Services, where Health Services will maintain the files. **Health Services will not administer Supplements to Student Athletes.**

PARENTAL CONSENT FOR PERMITTED SUPPLEMENT USE

Date _____ Name _____ Sport _____
MM/DD/YYYY

Permit the following supplements on campus:

☐ Multivitamins

☐ Proteins

☐ Omega 3s**

☐ Calcium/Vitamin D**

☐ None

**Prescription Required

Please Initial:

_____ I am aware that any non-permissible supplements will be immediately discarded.

The athlete is fully responsible for what they put into their body. By signing this page and authorizing or approving the designee to utilize dietary supplement(s), I hereby take full responsibility for the use of these supplements and do not hold IMG and IMG Academy related entities, personnel and/or staff responsible for these choices.

Student's signature: _____

Student's parent or legal guardian signature: _____

ImPACT TESTING

Dear IMG Academy Parents,

With the growing number of contact sports on campus and the increasing awareness of the potential danger of head injuries, IMG Academy is requiring baseline ImPact testing for all Baseball, Football, Soccer, Lacrosse and Basketball student athletes. Returning student-athletes that received baseline testing last year will not need to be re-tested.

We know that approximately 300,000 high school students in the United States experience a head injury or concussion every year. This represents approximately 19% of athletes who participate in contact sports. It is a staggering number and a very serious issue for our student athletes. The IMG Academy Athletic Training staff will be performing this mandatory baseline ImPact testing.

ImPACT Testing (Immediate Post-Concussion Assessment and Cognitive Testing) is a neurocognitive assessment tool that will assist doctors, athletic trainers, and healthcare professionals in determining your son or daughter's neurocognitive ability to return to play after suffering a head injury or concussion. In fact, neurocognitive testing has been called the "cornerstone" of proper concussion management by an international panel of sports medicine experts.

The baseline testing will be available to all other non-contact sport athletes at the request of the parents but is not mandatory for those student athletes. We will be administering the testing in September and your student athlete will be given a date and time to report for their testing. Baseline ImPact testing is not covered by insurance and therefore the mandatory testing fee of $25.00 will be deducted from the $300 medical account fee required for boarding students. The credit card on file will be charged for non-boarding students.

Should your child sustain a head injury at a later date, the physician will be able to administer a post-injury cognitive assessment that would provide an objective evaluation of the seriousness of the head injury and track recovery for safe return to play. Given the inherent difficulties in concussion management, it is important to handle concussions on an individualized basis and to implement baseline and post-injury neurocognitive testing to properly analyze when your child is ready to return to play. This is designed to prevent a more serious problem which is "second impact syndrome," or being re-injured before the initial injury is fully healed.

Sharon Zimmerman RN, BSN
Director of Health Services

EL2

Revised 03/10

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.

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
___ Neck	___ Forearm	___ Thigh
___ Back	___ Wrist	___ Knee
___ Chest	___ Hand	___ Shin/Calf
___ Shoulder	___ Finger	___ Ankle
___ 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

Revised 05/14

Consent and Release from Liability Certificate (Page 1 of 2)

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):** _____

Part 1. Student Acknowledgement and Release (to be signed by student at the bottom)

I have read the (condensed) FHSAA Eligibility Rules printed on the reverse side of this "Consent and Release Certificate" and know of no reason why I am not eligible to represent my school in interscholastic athletic competition. If accepted as a representative, I agree to follow the rules of my school and FHSAA and to abide by their decisions. I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury, including the potential for a concussion, and even death, is possible in such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved. Should I be 18 years of age or older, or should I be emancipated from my parent(s)/guardian(s), I hereby release and hold harmless my school, the schools against which it competes, the school district, the contest officials and FHSAA of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against FHSAA because of any accident or mishap involving my athletic participation. I hereby authorize the use or disclosure of my individually identifiable health information should treatment for illness or injury become necessary. I hereby grant to FHSAA the right to review all records relevant to my athletic eligibility including, but not limited to, my records relating to enrollment and attendance, academic standing, age, discipline, finances, residence and physical fitness. I hereby grant the released parties the right to photograph and/or videotape me and further to use my name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein. I understand that the authorizations and rights granted herein are voluntary and that I may revoke any or all of them at any time by submitting said revocation in writing to my school. By doing so, however, I understand that I will no longer be eligible for participation in interscholastic athletics.

Part 2. Parental/Guardian Consent, Acknowledgement and Release (to be completed and signed by a parent(s)/guardian(s) at the bottom; where divorced or separated, parent/guardian with legal custody must sign.)

A. I hereby give consent for my child/ward to participate in any FHSAA recognized or sanctioned sport **EXCEPT** for the following sport(s):

_____

List sport(s) exceptions here

B. I understand that participation may necessitate an early dismissal from classes.

C. I know of, and acknowledge that my child/ward knows of, the risks involved in interscholastic athletic participation, understand that serious injury, and even death, is possible in such participation and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. With full understanding of the risks involved, I release and hold harmless my child's/ward's school, the schools against which it competes, the school district, the contest officials and FHSAA of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against the FHSAA because of any accident or mishap involving the athletic participation of my child/ward. I authorize emergency medical treatment for my child/ward should the need arise for such treatment while my child/ward is under the supervision of the school. I further hereby authorize the use or disclosure of my child's/ward's individually identifiable health information should treatment for illness or injury become necessary. I consent to the disclosure to the FHSAA, upon its request, of all records relevant to my child/ward's athletic eligibility including, but not limited to, records relating to enrollment and attendance, academic standing, age, discipline, finances, residence and physical fitness. I grant the released parties the right to photograph and/or videotape my child/ward and further to use said child's/ward's name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein.

D. I am aware of the potential danger of concussions and/or head and neck injuries in interscholastic athletics. I also have knowledge about the risk of continuing to participate once such an injury is sustained without proper medical clearance.

READ THIS FORM COMPLETELY AND CAREFULLY. YOU ARE AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA USES REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH, TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

E. I agree that in the event we/I pursue litigation seeking injunctive relief or other legal action impacting my child (individually) or my child's team participation in FHSAA state series contests, such action shall be filed in the Alachua County, Florida, Circuit Court.

F. I understand that the authorizations and rights granted herein are voluntary and that I may revoke any or all of them at any time by submitting said revocation in writing to my school. By doing so, however, I understand that my child/ward will no longer be eligible for participation in interscholastic athletics.

G. Please check the appropriate box(es):

____ My child/ward is covered under our family health insurance plan, which has limits of not less than $25,000.

Company: _____ **Policy Number:** _____

____ My child/ward is covered by his/her school's activities medical base insurance plan.

____ I have purchased supplemental football insurance through my child's/ward's school.

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE (Only one parent/guardian signature is required)

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

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE (student must sign)

_____	_____	_____/_____/_____
Name of Student (printed)	Signature of Student	Date

Florida High School Athletic Association

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Consent and Release from Liability Certificate (Page 2 of 2)

This completed form must be kept on file by the school.

Attention Student and Parent(s)/Guardian(s)

Your school is a member of the Florida High School Athletic Association (FHSAA) and follows established rules. To be eligible to represent your school in interscholastic athletics, in an FHSAA recognized sport (i.e. bowling, competitive cheerleading, girls flag football, lacrosse, boys volleyball, water polo and girls weightlifting or sanctioned sport (i.e. baseball, basketball, cross country, tackle football, golf, soccer, fast-pitch softball, swimming & diving, tennis, track & field, girls volleyball, boys weightlifting and wrestling), the student:

1. Must be regularly enrolled and in regular attendance at your school. **If the student is a home education student or attends a charter school or Florida Virtual School - Full time Program or a special/alternative school or certain small non-member private schools, the student must declare in writing his/her intention to participate in athletics to the school at which the student is permitted to participate.** Home education students and students attending small non-member private schools must must be approved through the use of a separate form prior to any participation. (FHSAA Bylaw 9.2, Policy 16 and Administrative Procedure 1.8)
2. Must attend school within 10 days of the beginning of **each semester** to be eligible during **that semester**. (FHSAA Bylaw 9.2)
3. Must maintain at least a cumulative 2.0 grade point average on a 4.0 unweighted scale prior to the semester in which the student wishes to participate. This GPA must include all courses taken since the student entered high school. A sixth, seventh or eighth grade student must have earned at least a 2.0 grade point average on 4.0 unweighted scale the previous semester. (FHSAA Bylaw 9.4)
4. Must not have graduated from any high school or its equivalent. (FHSAA Bylaw 9.4)
5. Must participate at the school in which the student first enrolls (attends), or at which the student first takes part in an athletic practice, at the beginning of the school year. (FHSAA Bylaw 9.2)
6. Must not transfer schools after the first day of practice of a sport, otherwise the student cannot participate at the new school for the remainder of that sport season. Exceptions may apply. See your school's principal/athletic director after first attending the new school. (FHSAA Bylaw 9.3)
7. Must not participate on a non-school team (i.e., AAU, American Legion, club setting, etc.) which is affiliated with a school or coached by a representative of a school other than the one the student attends, or has attended, and then attend that school, otherwise the student's eligibility may be impacted. (FHSAA Bylaw 9.2) Exceptions may apply. See your school's principal/athletic director after first attending the new school.
8. Must not transfer to a school that the student's coach has relocated to within a year, otherwise the student's eligibility may be impacted. (FHSAA Bylaw 9.3)
9. Must not have **enrolled in the ninth grade for the first time** more than four school years ago. If the student is a sixth, seventh or eighth grade student, the student must not participate if repeating that grade. (FHSAA Bylaw 9.5)
10. Must have signed permission to participate from the student's parent(s)/legal guardian(s) on a form (EL3) provided the school. (Bylaw 9.8)
11. Must be less than 19 years 9 months old to participate in high school; 16 years 9 months old to participate in junior high school; and 15 years 9 months old to participate in middle school, otherwise the student becomes ineligible to participate at that level. Students entering 9th grade in 2014-15 and thereafter must not turn 19 before September 1st, otherwise the student becomes ineligible to participate. (FHSAA Bylaw 9.6)
12. Must undergo a pre-participation physical evaluation and be certified as being physically fit for participation in interscholastic athletics (form EL2). The physical evaluation is valid for 365 calendar days from the date that it was administered. Parents and students must also submit a completed EL3CH which serves to address heat illness and concussion dangers. (FHSAA Bylaw 9.7)
13. Must be an amateur. This means the student must not accept money, gift or donation for participating in a sport, or use a name other than his/her own when participating. (FHSAA Bylaw 9.9)
14. Must not participate in an all-star contest in a sport prior to completing his/her high school eligibility in that sport. (FHSAA Policy 26)
15. Must display good sportsmanship and follow the rules of competition **before, during and after** every contest in which the student participates. If not, the student may be suspended from participation for a period of time. (FHSAA Bylaw 7.1)
16. Must not provide false information to his/her school or to the FHSAA to gain eligibility. (FHSAA Bylaw 9.1)
17. Youth exchange, other international and immigrant students must be approved by the FHSAA office prior to any participation. Exceptions may apply. See your school's principal/athletic director. (FHSAA Policy 17)
18. Must refrain from hazing/bullying while a member of an athletic team or while participating in any athletic activities sponsored by or affiliated with a member school.
19. **This form is non-transferable**; a separate form must be completed for each different school at which a student participates.

If the student is declared or ruled ineligible due to one or more of the FHSAA rules and regulations, the student has the right to request that the school file an appeal on behalf of the student. See the principal or athletic director for information regarding this process.

Florida High School Athletic Association

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Consent and Release from Liability Certificate for Concussion and Heat-Related Illness (Page 1 of 2)

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.

Concussion Information

What is a concussion?

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 can't 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.

What are the signs and symptoms of 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

What can happen if my child keeps on playing 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.

What do I do if I suspect my child has suffered a concussion?

Any athlete suspected of suffering a concussion should be removed from the activity immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without written medical clearance from an appropriate health-care professional (AHCP). In Florida, an appropriate health-care professional (AHCP) is defined as either a licensed physician (MD, as per Chapter 458, Florida Statutes), a licensed osteopathic physician (DO, as per Chapter 459, Florida Statutes). Close observation of the athlete should continue for several hours. You should also seek medical care and inform your child's coach if you think 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.

When can my child return to play or practice?

Following physician evaluation, the ***return to activity process*** requires the athlete to be completely symptom free, after which time they would complete a step-wise protocol under the supervision of a licensed athletic trainer, coach or medical professional and then, receive written medical clearance of an AHCP.

For current and up-to-date information on concussions, visit http://www.cdc.gov/concussioninyouthsports/ or http://www.seeingstarsfoundation.org

Statement of Student Athlete Responsibility

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 of participation for myself and that of my child/ward.

Name of Student-Athlete (printed)	Signature of Student-Athlete	Date
		_____/_____/_____

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

Florida High School Athletic Association

Revised 05/14

Consent and Release from Liability Certificate for Concussion and Heat-Related Illness (Page 2 of 2)

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.

FHSAA Heat-Related Illnesses Information

People suffer heat-related illness when their bodies cannot properly cool themselves by sweating. Sweating is the body's natural air conditioning, but when a person's body temperature rises rapidly, sweating just isn't enough. Heat-related illnesses can be serious and life threatening. Very high body temperatures may damage the brain or other vital organs, and can cause disability and even death. Heat-related illnesses and deaths are preventable.

Heat Stroke is the most serious heat-related illness. It happens when the body's temperature rises quickly and the body cannot cool down. Heat Stroke can cause permanent disability and death.

Heat Exhaustion is a milder type of heat-related illness. It usually develops after a number of days in high temperature weather and not drinking enough fluids.

Heat Cramps usually affect people who sweat a lot during demanding activity. Sweating reduces the body's salt and moisture and can cause painful cramps, usually in the abdomen, arms, or legs. Heat cramps may also be a symptom of heat exhaustion.

Who's at Risk?
Those at highest risk include the elderly, the very young, people with mental illness and people with chronic diseases. However, even young and healthy individuals can succumb to heat if they participate in demanding physical activities during hot weather. Other conditions that can increase your risk for heat-related illness include obesity, fever, dehydration, poor circulation, sunburn, and prescription drug or alcohol use.

By signing this agreement, the undersigned acknowledges that the information on page 1 and page 2 have been read and understood.

Name of Student-Athlete (printed)	Signature of Student-Athlete	Date
		_____/_____/_____

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

Florida High School Athletic Association Clearance for Participation Form

GA7

Revised 06/12

The following information **MUST** be completed before the student will be allowed to participate in athletics at an FHSAA member school.

The student **MUST** have each of the categories below completed before equipment will be issued and/or the student is allowed to participate in tryouts, practices or contests.

To be completed by the student: Please **PRINT** all information clearly.

_____ _____

Student's OFFICIAL Full Name | Date of Birth (mm/dd/yy)

_____ _____

School Attended the Previous School Year | Current Grade Level

_____

Sport (a separate form MUST be used for each sport)

To be completed by school official only:

ELIGIBLE: [ ] YES [ ] NO _____

Athletic Office Staff

REASON NOT ELIGIBLE: [ ] GPA [ ] LIMIT EXPIRED [ ] PROOF OF AGE NEEDED

MISSING FORM (if applicable): [ ] EL4 [ ] EL7 [ ] EL12 [ ] EL14

PHYSICAL ON FILE (EL2 Form) _____

Athletic Office Staff

Date of Exam _____

CONSENT/RELEASE ON FILE (EL3 Form) _____

Athletic Office Staff

CONCUSSION/HYDRATION RELEASE ON FILE (EL3CH Form) _____

Athletic Office Staff

[ ] GA4 [ ] GA6 FORM ON FILE _____

(if applicable) Athletic Office Staff

[ ] STUDENT HAS BEEN ADDED TO _____

THE C2CSchools DATABASE Athletic Office Staff