

# Athletic Participation Forms

## ALL ATHLETIC FORMS ARE NOW COMPLETED ONLINE BY

**PARENTS/GUARDIANS-** We will not accept participation packets anymore. Parents need follow instructions below to input everything and to download the completed physical and notary form all on athleticclearances.com. **Coaches will not collect paperwork.** This must be completed before attending tryouts or practice. If you are having problems filling out the athletic clearance direct questions to the help chat on the website – please do not call the Coach or Athletic Director as they cannot control the site. Once you have completed the signup it will say “pending” – the Athletic Director will be approving athletes twice a week. If your account says “in progress” you have not completed all the steps by parent and athlete. No athlete will be allowed to participate without an account and completed paperwork.

**Before attending any conditioning or tryouts, you MUST create an account on <https://athleticclearance.com> – the following are the MUST HAVE forms...detailed instructions follow.**

You will need to have completed by a doctor the FHSAA EL2 all three pages. This must have the athletes name. This must be signed and dated by the doctor. It must be checked where it says cleared without limitations. If any of this is not filled out the clearance will be denied and your athlete will not be able to participate until completed correctly.

You will also need to have filled out and notarized the Pasco County Participation Form.

All forms and further information can be found at:  
<https://www.pasco.k12.fl.us/athletics/page/forms/>

**THESE ARE THE ONLY TWO FORMS NEEDED TO COMPLETE THE ATHLETIC CLEARANCE.**

## DETAILED INSTRUCTIONS

**ATHLETIC CLEARANCE – Quick steps for parents/students using the online athletic clearance process.**

1. Visit [athleticclearance.com](https://athleticclearance.com). Click on the Florida Picture
2. Click on “**Create an Account**” and follow steps. Or sign in if you have previously created an account. Watch tutorial video if help is needed.
3. **Register.** PARENTS register with valid email username and password
4. Login using your email address that you registered with
5. Select “**Start Clearance Here**” to start the process.
6. Choose the School Year in which the student plans to participate. *Example: Football in Sept 2021 would be the 2021-2022 School Year.*  
Choose the School at which the student attends and will compete for.

Choose Sport. \*You can also “Add New Sport” if a multi-sport athlete. Electronic signatures will be applied to the additional sports/activities.

7. Complete all required fields for Student Information, Educational History, Medical History and Signature Forms. **(If you have gone through the AthleticClearance.com process before, you will select the Student and Parent/Guardian from the dropdown menu on those pages)**
8. Once you reach the **Confirmation Message** you have completed the process.
9. All of this data will be electronically filed with your school’s athletic department for **review**. When the student has been **cleared for participation**, an email notification will be sent.

## Online Athletic Clearance FAQ

### What is my Username?

Your username is the email address that you registered with.

### Multiple Sports

On the first step of the process you have the ability to “Add New Sport”. If you use this option, you fill out the clearance one time and it is applied to the sport selected. If you complete a clearance and come back at a later date to add a sport, you will “Start New Clearance” and then autofill student and parent information using the dropdown menus on those pages.

### Physicals

The physical form can be downloaded on Files page.

### Why haven’t I been cleared?

Your school will review the information you have submitted and Clear, Clear for Practice or Deny your student for participation. You will receive an email when the student’s status is updated.

### My sport is not listed!

Please contact your school’s athletic department and ask for your sport to be activated.

**ATHLETIC FEES:** There are no try-out fees. Once a student is selected for a team, a fee will be due: \$80.00 for high school students. The fee for the second sport is \$50.00 for high school students. The individual cap for high schools is \$130.00. The total family fee (for the same school) is \$210.00 for high schools. A student will not be allowed to dress out, participate in a game or be considered part of the team until the full fee is paid.

**NO Tryout Fee:** Students have three (3) days to pay fees after they make the team. No one will participate in game competition until fees have been paid. Please be aware that the participation fee does not guarantee playing time, only the opportunity to be on the team if selected.



**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 1/26

**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 1/26

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ School: \_\_\_\_\_

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

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

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

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine physical evaluation required by Florida Statute 1006.20, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test. The FHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: \_\_\_\_\_ (printed) Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ (printed) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ (printed) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



**PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)**  
*This medical history form should be retained by the healthcare provider and/or parent.  
 This form is valid for 365 calendar days from the date of exam.*

**EL2**

Revised 1/26

**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**

	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>
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**

	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>
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 2/26

### 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 Form EL1/2S 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, or a practitioner who holds an active equivalent licensure issued by the state in which the medical evaluation was performed 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.



**ELECTROCARDIOGRAM (ECG) SCREENING (Page 1 of 1)**  
SUBMIT THIS CLEARANCE FORM TO THE SCHOOL

**EL1**

Revised 2/26

**ELECTROCARDIOGRAM (ECG) SCREENING 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: \_\_\_\_\_ Student ID: \_\_\_\_\_

**Parent/Guardian:** Review the FHSAA EL3 Consent and Release form for details on Sudden Cardiac Arrest. Per §1006.20, F.S. (Second Chance Act), effective July 1, 2026, all first-time high school participants in FHSAA athletics must have an Electrocardiogram (ECG) screening before participation. This applies to students with no cardiac symptoms. Students with cardiac symptoms should consult their healthcare provider. An ECG completed within two (2) years prior to July 1 of the participation year satisfies this requirement. If the ECG requires further evaluation, the student must be cleared by a licensed medical practitioner trained in the diagnosis, evaluation and management of ECGs before participating in FHSAA athletic competition, practice, tryouts, or workouts.

**Please complete only ONE section (Section A or Section B, as applicable)**

**SECTION A: PARENT/GUARDIAN ATTESTATION (Select one and sign below)**

ECG completed by Who We Play For, a hospital in the state of Florida, or another healthcare organization and electronically signed by a licensed physician; attach normal result documentation from health record or the email received from provider.

Date of NORMAL ECG Result: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Organization Performing ECG: \_\_\_\_\_

OR

Medical Exception - Attach FHSAA Form ME1

Religious Objection - I object to an ECG for my child based on religious reasons allowed by law

Parent/Guardian Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SECTION B: LICENSED PRACTITIONER ATTESTATION - ECG Interpretation by healthcare provider**

In accordance with §1006.20(2)(c), F.S., I certify I am a licensed practitioner (Ch. 458, 459, 460, 464.012, 464.0123 F.S. or equivalent) familiar with the "International Criteria for ECG interpretation in student-athletes". If the ECG is normal, complete the section below. If further evaluation is required, the student should be referred to a practitioner trained in the diagnosis, evaluation and management of ECGs.

Normal ECG (no additional evaluation required)  
 Normal variant ECG based on the International Criteria (no additional evaluation required)  
 Further evaluation by a licensed medical professional is required, and an EL1/2S must be completed

Provider Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Credentials: \_\_\_\_\_ License#: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*If your ECG requires further evaluation and you need help accessing cardiology follow-up care, please visit [www.whoweplayfor.org](http://www.whoweplayfor.org).*

Please retain a copy for your records.



## MEDICAL ELIGIBILITY SUPPLEMENTAL FORM

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

*This form is only required one time if used as a supplement to the EL1.*

*This form is valid for 365 calendar days from the date of exam if used as a supplement to the EL2.*

**EL1/2S**

Revised 2/26

### MEDICAL ELIGIBILITY SUPPLEMENTAL FORM - Referred Provider Form

*The Medical Eligibility Supplemental Form is required when a student must obtain further evaluation by a qualified medical specialist prior to clearance for participation in interscholastic athletics.*

*This form supplements eligibility documentation for referrals originating from either the EL1 - ECG Screening Form or the EL2 - Preparticipation Physical Evaluation. This form documents the specialist's evaluation, recommendations, and clearance status related to the medical concern identified during the initial screening/evaluation.*

*Completion of all applicable sections by the appropriate specialist is required before athletic clearance may be granted.*

#### 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)*



# DISTRICT SCHOOL BOARD OF PASCO COUNTY PARENT RELEASE

MIS Form #166  
Rev. 01/18

## TRANSPORTATION BY:

School Bus/Van  Private  Vehicle  Walking  Charter Bus  PCPT

Date of Field Trip \_\_\_\_\_

Sponsor \_\_\_\_\_

In consideration of \_\_\_\_\_  
Student Name - Please Print \_\_\_\_\_ Date of Birth \_\_\_\_\_

principal, teacher(s) or other personnel of \_\_\_\_\_ School of the District School

Board of Pasco County to go on a school sponsored trip to \_\_\_\_\_, and I, the undersigned, understand that my child, if transported by a privately owned vehicle, charter bus, school bus or walking, hereby release the District School Board of Pasco County, the individual members of said Board, the Superintendent, the principal, teachers or other employees of the school, and volunteer leaders from any financial responsibility because of sickness of the student while going to, returning from, or attending said field trip or because of any accident in which the student is injured. To ensure prompt attention in case of sickness or accident, I hereby authorize the person(s) in charge of said trip to incur expense considered necessary for treatment, and I agree to pay for same if this is in excess of the amount paid by any accident or health insurance policy that may be in effect at the time of the sickness or accident.

In any situation in which the safety and security of students might be compromised (e.g., Red Alert Status issued by the Department of Homeland Security, severe weather conditions, etc.) the District School Board of Pasco County will take the necessary steps to ensure the safety of its students and staff, including the cancellation of scheduled field trips and school events. Should this trip or event be cancelled as a result of such an event, the District cannot guarantee any monies (including deposits) will be refunded by the vendor(s) associated with this transaction. Therefore, students, parents, guardians, etc., are hereby cautioned and advised that the District will not be liable for any reimbursements associated with this event that are not refunded by the vendor(s) and returned to the District.

I have documented below all precautions/instructions regarding my child's medication. I have noted any special health related conditions or allergies regarding my child. I understand that the trained school employee who usually dispenses medication may or may not be present during the trip. Medications will be dispensed by a trained school employee (in accordance with Board Policy 5330).

Please list any medication(s) your child is currently taking (at home or school): (Dosages/Times)

Allergies: \_\_\_\_\_ Additional Health Concerns: \_\_\_\_\_

Name of Parent or Guardian – Please Print

Date

Signature of Parent or Guardian

Primary Phone

Alternate Phone

Business Phone

Street, Rural Route, or P.O. Box

City

State

Zip Code

Name of Additional Emergency Contact / Relationship to Student

Phone