



**Board Members**

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**Superintendent**

E. Wayne Gent

Dear Parents/Guardians and Students,

St. Lucie West K-8 School will offer the following activities for 2015-2016 to all middle school students (grades 6-8) who meet the criteria listed below: Volleyball (girls), Co-ed Soccer, Basketball (boys/girls), and track. In intramural sports, students play against each other and have an end of the season tournament where the coach will place students into team(s) to compete against other schools in the district. A practice schedule will be provided to each student at the first practice for each sport. Parents/Guardians will also be asked to sign up for Remind 101 as another means of communication.

**In order to participate in practice, you must have a sports packet completed, the packet must be notarized, and pay a one-time \$20.00 processing and insurance fee. This must be turned in to Coach Kosinski BEFORE the first practice. Students will not be able to participate if the packet is not returned, notarized, or missing the \$20.00 payment.**

- Academics:** Each student must have a 2.0 grade point average to be able to practice and participate in games. The student cannot have any failing grades (F) in any subjects. Grades will be checked on a bi-weekly basis utilizing the Student-Athlete Grade Sheet Form.
- Behavior:** The student must maintain proper conduct in accordance with the policy set by the St. Lucie County School Board. Any student who receives a referral while in season, will be removed from the team.
- Athletic Packets:** All students who want to participate in intramural sports must have a completed physical packet with a consent and release form signed and notarized BEFORE they can begin practice. All packs/consent and release forms must be turned in to Coach Kosinski. The physical forms/consent and release can be downloaded by going to [www.SLWK8PE.weebly.com](http://www.SLWK8PE.weebly.com) and click on athletics. A one-time \$20.00 processing and insurance fee must be paid at the time you turn in your sports packet. A receipt and clearance card will be issued to each student when received by Coach Kosinski.
- Good Sports Citizenship:** It is extremely important to teach the values of good sport citizenship to the students. If a player is removed from a game or practice, the student will lose their privilege of participating in ANY intramural sport at St. Lucie West K-8 School for the remainder of the year.
- All student must have their ride pick them up promptly on practice days.** If a student is not picked up on time, they will receive a warning. If the student is not picked up promptly after the warning, they could lose their privilege of practicing in intramural sports.

_____	_____
Student/Player Signature	Date
_____	_____
Parent/Guardian Signature	Date



**St. Lucie West K-8 School**

1501 SW Cashmere Blvd., Port St. Lucie, FL 34986

772.785.6630 - Fax 772.785.6632

Accredited System-wide by the Southern Association of Colleges and Schools

The School Board of St. Lucie County is an Equal Opportunity Agency

*"Offering an Ocean of Learning Opportunities"*



**SCHOOL BOARD OF ST. LUCIE COUNTY, FLORIDA  
MIDDLE SCHOOL INTRAMURAL, PERMISSION, AND RELEASE**

Name of Student Participant (Please print) \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Parent/Guardian Work Phone \_\_\_\_\_ Other Emergency /Cell Phone \_\_\_\_\_

School \_\_\_\_\_ Grade Level \_\_\_\_\_ Sport(s) \_\_\_\_\_

I/We, the undersigned Parent(s)/Guardian(s) of the above named student, acknowledge that participating in middle school intramurals in the St. Lucie County Schools is entirely voluntary and subject to the rules and policies of the St. Lucie County School District. I understand that my child must abide by all the rules set down by the School Board of St. Lucie County and the school in which the Student Participant is enrolled (School). All infractions of the Code of Student Conduct shall be reported to school administration. All infractions are subject to the appropriate Discipline Response as defined in The School Board of St. Lucie County Code of Student Conduct.

Student participants and parents or guardians of Student participants should have a thorough understanding of the responsibilities and implications of participating in a voluntary extracurricular activity. For this reason, each Student Participant in the St. Lucie County Schools and his/her parent(s), or guardian(s), shall read, and sign this agreement, permission, and release prior to the Student Participant being allowed to participate in any form of intramural practice or contests.

I/We, the undersigned Parent(s)/guardian(s) of the above name Student Participant:

1. Understand that I must have a current physical on file at the school and a completed permission and release form.
2. Understand that only a supplementary insurance premium for the Student Participant is to be paid from school board funds. This insurance will have a **\$500.00** deductible. This deductible will be applied concurrent with primary coverage which will be paid at 100% Reasonable and Customary. If there is no primary coverage, this insurance will pay 100% of Reasonable and Customary after the **\$500.00** deductible.
3. Understand that a **TWENTY DOLLAR (\$20.00) NON-REFUNDABLE PROCESSING FEE must be paid when this form is submitted.** This fee does guarantee participation in the Intramural program at the school your child attends; **however it does not guarantee selection to a tournament team.** I also understand that additional fees may be assessed to participate in a specific sport due to financial limitations and the uncertainty of financial times.
4. Understand that in the event of accident or injury, only School required accident forms will be completed by School officials, and that all claims under any applicable insurance policy for injuries received while participating in intramural activities or travel incidental to such activities shall be processed by the Parent(s)/guardian(s) or the student participant through the company agent handling the insurance policy, and **not** through School officials.
5. Authorize the School to transport the Student Participant and to obtain, through a physician of the School's choice, any emergency medical care that may become reasonably necessary for the student in the course of intramural activities or travel incidental to such activities; and agree that the expenses for such transportation and treatment shall not be borne by the School Board or its employees.
6. **I understand that talking to a coach or someone from any high school about playing at his/her school before you begin attending that school is a violation and could result in:**  
(FHSAA Policy 36)
  - a. You being ineligible for a year;
  - b. The coach may be fined and suspended;
  - c. The school may face penalties including fines and not making the playoffs.

Please visit WWW.SLWK&PE.WEBLY.COM for athletic form deadlines, practice schedules, tournament dates, etc.

**NOTICE TO PARENTS/GUARDIANS OF MINOR CHILD PARTICIPANTS**

**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 THE SCHOOL DISTRICT OF ST. LUCIE COUNTY, ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS USE 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' RIGHT AND YOUR RIGHT TO RECOVER FROM ST. LUCIE COUNTY SCHOOL DISTRICT 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 THE ST. LUCIE COUNTY SCHOOL DISTRICT HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.**

I/WE, THE UNDERSIGNED PARENT(S) AND STUDENT PARTICIPANT ACKNOWLEDGE HAVING RECEIVED AN ADEQUATE OPPORTUNITY TO REVIEW THIS AGREEMENT, PERMISSION, AND RELEASE AND TO ASK QUESTIONS OF SCHOOL OFFICIALS. I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AGREEMENT; THAT I AGREE TO ITS TERMS; THAT I WILL COMPLY WITH ALL SCHOOL BOARD AND STATE ASSOCIATION RULES. IT IS UNDERSTOOD THAT THE STUDENT ATHLETE IS REQUIRED TO COMPLY WITH ALL SAFETY RULES AND INSTRUCTIONS PROVIDE WITH EACH SPORT, COMPETITION, AND PRACTICE WHILE ENGAGING IN SUCH ACTIVITIES.

**I/WE UNDERSTAND THAT PARTICIPATION IN INTERSCHOLASTIC ATHLETICS IS A PRIVILEGE. FURTHERMORE, WE/I UNDERSTAND THAT THE PRINCIPAL OR DESIGNEE HAS THE SOLE DISCRETION TO WITHDRAW MY ELIGIBILITY AT ANY TIME DUE TO AN ON-CAMPUS OR OFF-CAMPUS BEHAVIOR THAT IS DEEMED BY THE PRINCIPAL OR DESIGNEE TO BE UNBECOMING OF A STUDENT ATHLETE.**

-----Acknowledgment of Parent/Guardian Signature)-----

Print Parent/Guardian Name \_\_\_\_\_ Date \_\_\_\_\_

Sign Parent/Guardian Name (In presence of Notary) \_\_\_\_\_

STATE OF FLORIDA  
COUNTY OF ST. LUCIE

The foregoing instrument was acknowledged before me this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, by \_\_\_\_\_ He/She is \_\_\_\_ personally known to me, or \_\_\_\_ has produced \_\_\_\_\_ as identification, and \_\_\_\_ did \_\_\_\_ did not take an oath.

(Notary Seal) My Commission Expires \_\_\_\_\_

Notary Public State of Florida \_\_\_\_\_

Print Notary Name \_\_\_\_\_



Preparticipation Physical Evaluation (Page 1 of 3)



This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2. This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.

Part 1. Student Information (to be completed by student or parent)

Student's Name: School: Grade in School: Sport(s): Sex: Age: Date of Birth: Home Address: Name of Parent/Guardian: Home Phone: Person to Contact in Case of Emergency: F-mail: 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.

- 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, Neck, Back, Chest, Shoulder, Upper Arm, Elbow, Forearm, Wrist, Hand, Finger, Foot, Hip, Thigh, Knee, Shin/Calf, Ankle. 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, Hepatitis B, Chickenpox. FEMALES ONLY (optional) 42. When was your first menstrual period? 43. When was your most recent menstrual period? 44. How much time do you usually have from the start of one period to the start of another? 45. How many periods have you had in the last year? 46. What was the longest time between periods in the last year?

Explain "Yes" answers here:

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

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



Revised 05/14



# Florida High School Athletic Association Preparticipation Physical Evaluation (Page 2 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2. This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.

### Part 3. Physical Examination (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).

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

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ % Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_.\_\_\_\_/\_\_\_\_)

Temperature: \_\_\_\_\_ Hearing: right: P \_\_\_\_ F \_\_\_\_ left: P \_\_\_\_ F \_\_\_\_

Visual Acuity: Right 20/\_\_\_\_ Left 20/\_\_\_\_ Corrected: Yes \_\_\_\_ No \_\_\_\_ Pupils: Equal \_\_\_\_ Unequal \_\_\_\_

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
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#### MEDICAL

1. Appearance \_\_\_\_\_
2. Eyes/Ears/Nose/Throat \_\_\_\_\_
3. Lymph Nodes \_\_\_\_\_
4. Heart \_\_\_\_\_
5. Pulses \_\_\_\_\_
6. Lungs \_\_\_\_\_
7. Abdomen \_\_\_\_\_
8. Genitalia (males only) \_\_\_\_\_
9. Skin \_\_\_\_\_

#### MUSCULOSKELETAL

10. Neck \_\_\_\_\_
11. Back \_\_\_\_\_
12. Shoulder/Arm \_\_\_\_\_
13. Elbow/Forearm \_\_\_\_\_
14. Wrist/Hand \_\_\_\_\_
15. Hip/Thigh \_\_\_\_\_
16. Knee \_\_\_\_\_
17. Leg/Ankle \_\_\_\_\_
18. Foot \_\_\_\_\_

\* - station-based examination only

#### ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

\_\_\_\_ Cleared without limitation

Disability: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Precautions: \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Referred to \_\_\_\_\_ For: \_\_\_\_\_

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

Name of Physician/Physician Assistant/Nurse Practitioner (print): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Signature of Physician/Physician Assistant/Nurse Practitioner: \_\_\_\_\_