2600 Upper Park Rd
Orlando, FL 32814
407-623-1415
https://glenridgems.ocps.net/

Daniel Kempinger - Principal
daniel.kempinger@ocps.net

David Stock - Athletic Director
david.stock@ocps.net
ext: 5072228

GlenridgeSportsParticipationPhysical

New to OCPS is the **Aktivate** site for uploading forms. Information is on the following page. **Please allow 24 hours for your eligibility to be processed.** Paperwork will not be accepted if there is any missing information and/or signatures.

Physicals are good for one calendar year. If the date of your physical exam expires during your sport's season, you will not be allowed to participate until a new physical is received. A violation of this may cause the team to forfeit contests and/or be fined by the FHSAA.

We ***STRONGLY*** recommend completing school physicals at the end of May and/or turn in physical before school ends.

**Forms Need to be completed & Uploaded on the Aktivate Website: www.aktivate.com **

FHSAA Preparticipation Physical Evaluation (EL2)
Page 1& 2: Complete Medical History and signatures.
* Please explain any 'yes' answers in the space provided on page 2

Page 3: Complete Student's Full Name, DOB, and School at the top of the page only/ **leave rest of page blank for the medical provider to fill out.**

Page 4: Complete Student Information (top of page) / Shared emergency information with signatures (at the bottom of the page) **/ leave center of page blank for the medical provider to fill out)**

Page 4 will be the form that you will upload into Aktivate in the sport's physical section once completed and signed by the medical provider.

PHYSICAL MUST BE ON FHSAA FORM ONLY
If the Physician does not stamp the physical in the box, print the Physician's name and phone number at the bottom. Make sure the physical date is listed.

Registration for Parents/Guardians

CREATE A PARENT/GUARDIAN ACCOUNT:

❏ On www.aktivate.com, click **Login**

❏ Click **Create an Account**

* *You only need ONE account, even if you have children in more than one high school and/or junior high*
* *Do not create another account if you have used Register My Athlete/Aktivate in the past*

❏ Fill in your personal account information. You will be using the site as a Parent/Guardian.

❏ Click **Create Account**

❏ Shortly after creating your account, you will receive an **email with a 6-digit Verification Code.** Use this code to verify your account when prompted.

* ***Do not close your current tab**. You will need to open your email in another tab and find the verification email in your email inbox (it may take a few minutes to appear, so be patient).*

REGISTER YOUR STUDENT FOR AN ACTIVITY:

❏ Login with your email address and password

❏ Under the **Parents** header, click the button labeled **Click here to start/complete athlete registrations**

❏ Click **Start/Complete Registrations** under "What would you like to do?"

❏ Click the **New Registration +** button in the upper right hand corner

❏ Start by clicking the red **Select School** bar and follow the directions as they appear

❏ Continue following the steps presented in the red bars

❏ Once your registration is complete, you'll receive a confirmation email from us

SCAN TO LEARN HOW TO CREATE AN ACCOUNT AND SUBMIT A REGISTRATION

Need Help? For a live chat, click the orange **Help** button Help? on the lower left side of the screen or email support@aktivate.com for assistance.

Glenridge Middle School
Sports Physical Information

To try out and/or participate in any of these sports you must ha e a physical exam and a completed sports physical form. <u>All</u> forms must be completed and signed prior to trying out for a sport.

The physical exam is valid for an entire year.

You may have your physical exam done by:

- Your private MD.
- A walk-in medical center.
- The nurse practitioner at Glenridge Middle School.

If you wish to have your physical exam done by the Nurse Practitioner at Glenridge, please call my office to make an appointment (407) 623-1415 ext. 5072245.

The physical exam at the Student Health Center at Glenridge is **free**.

If you have any questions, please feel free to call my office at (407) 623-1415 ext 5072245.

Darlene Berger, APRN
Pediatric Nurse Practitioner
Student Healthcare Center at Glenridge

Soccer Volleyball Basketball Track & Field

CONSENT FOR SCHOOL-BASED HEALTHCARE SERVICES

Orange County Public Schools
445 W. Amelia Street, Orlando FL 32801 407-317-3200
"The Orange County School Board is an equal opportunity agency"

Services provided by Healthcare Providers of Florida, Inc.

Minor Child Consent Form

Please read carefully and complete the following statement authorizing the provision of healthcare services from Healthcare Providers of Florida, Inc. to your minor child. Healthcare Providers of Florida, Inc. is a third party entity not owned or operated by Orange County Public Schools. Your child will be treated by an Advanced Practice Registered Nurse (APRN) from Healthcare Providers of Florida, Inc.

I hereby consent for my child _____ (first and last name) Date of Birth: _____

To receive the following services provided by Healthcare Providers of Florida, Inc.:

1. Comprehensive health history,
2. Physical examination for school entry and sports participation, including inguinal hernia exam for males,
3. Examination, diagnosis, testing and treatment for minor illnesses and injuries,
4. Screening for selected health problems,
5. Management of chronic illness,
6. Periodic screening for wellness, anticipatory guidance, preventive testing and treatment as outlined by Medicaid,
7. Referral to specialists,
8. Preventive health education,
9. Counseling, and/or
10. Administration of medication

Please list by number any services you **DO NOT** wish your child to receive: _____

I understand that the confidentiality of my child's medical records, as a patient receiving care, is required by law, and those records will not be released to any person or entity without prior permission. I hereby release Healthcare Providers of Florida, Inc. and Orange County Public Schools, along with their affiliates, directors, officers, employees, agents, successors and assigns, from any and all liability arising from or in any way connected to my child receiving these services. My signature below authorizes medical treatment, billing of insurance, if any, receipt of the notice of privacy rights as required by HIPAA, and confirms the accuracy of the Medical Information provided below.

Parent/Legal Guardian (print) _____

Phone (cell) _____ Phone (alternate) _____ Email_____

Address _____ City _____ Zip _____

School Attending _____

SIGNATURE _____ **DATE** __ _____

Medical Information

Medical Provider _____**Preferred Hospital** _____

Insurance: Yes __ No _ **Insurance Name**_____ **Type:** Private ___ Medicaid ____ Healthy Kids___

Medical History: Food/Drug Allergies _____ Current Medication(s) _____

Serious/Chronic Medical Conditions _____ Surgeries _____

Hospitalizations _____Other_____

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 signed below.

EL2

Revised 3/23

MEDICAL HISTORY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ 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 Questionaire 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 Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.	Yes	No
1	Do you have any concerns that you would like to discuss with your provider?		
2	Has a provider ever denied or restricted your participation in sports for any reason?		
3	Do you have any ongoing medical issues or recent illnesses?		
	HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4	Have you ever passed out or nearly passed out during or after exercise?		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7	Has a doctor ever told you that you have any heart problems?		

	HEART HEALTH QUESTIONS ABOUT YOU *(continued)*	**Yes**	**No**
8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10	Have you ever had a seizure?		
	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
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)		
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 catecholaminerigc polymorphic ventricular tachycardia (CPVT)?		
13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

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 signed below.

EL2

Revised 3/23

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

	BONE AND JOINT QUESTIONS	Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		
	MEDICAL QUESTIONS	**Yes**	**No**
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?		
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
22	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
23	Have you ever become ill while exercising in the heat?		
24	Do you or does someone in your family have sickle cell trait or disease?		
25	Have you ever had or do you have any problems with your eyes or vision?		

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

Explain "Yes" answers here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

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

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

Student-Athlete Name: _____ *(printed)* Student-Athlete Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ *(printed)* Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ *(printed)* Parent/Guardian Signature: _____ Date: ___ / ___ / ___

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 signed below.

EL2
Revised 3/23

PHYSICAL EXAMINATION FORM

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

PHYSICIAN 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?	

☐ Verify completion of FHSAA EL2 Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

EXAMINATION

Height: **Weight:**

BP: / (/) **Pulse:** **Vision:** R 20/ L 20/ **Corrected:** Yes No

MEDICAL - healthcare professional shall initial each assessment	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, Ears, Nose, and Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL - healthcare professional shall initial each assessment	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and Arm		
Elbow and Forearm		
Wrist, Hand, and Fingers		
Hip and Thigh		
Knee		
Leg and Ankle		
Foot and Toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

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

*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. The FHSAA Sports Medicine Advisory Committee strongly recommends to a student-athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___ / ___ / _____

Address: _____ Phone: (_____) _____ E-mail: _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 3/23

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ 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: (_____) _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

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

_____

I hereby certify that I 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: ___ / ___ / _____

Address: _____ Phone: (_____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

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.

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

PREPARTICIPATION PHYSICAL EVALUATION (Supplement)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 3/23

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

MEDICAL ELIGIBILITY FORM - Referred Provider Form

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ 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: ___ / ___ / _____

Address: _____ Phone: (_____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*