TOHOPEKALIGA HIGH SCHOOL ATHLETIC PARTICAPATION REQUIREMENTS CHECKLIST

*This checklist is for your convenience only, it does not need to be submitted to the school

____**Complete the 2023-24 Aktivate Registration at www.Aktivate.com**

____**Have a valid physical on file with TKHS Athletic Dept. *and* uploaded to Aktivate**
*Must be on the form in this packet. The school only requires EL2 page 4, and *possibly* page 5 if a referral is needed for medical clearance. Physicals are valid for 365 days (1 year).

____**Have a completed ECG clearance form on file with TKHS Athletic Dept. *and* uploaded to Aktivate**
*Completed once as an incoming freshman in high school, or later; ECG clearance is valid for all 4 years of high school athletic participation

____**Medical Authorization Form completed and uploaded to Aktivate**

____**Annual Baseline ImPACT test**- Instructions in this packet. This is required annually.

____**Paid Athletic Fee**- $35 paid to TKHS Athletics. This can be paid through Aktivate.

Non-Traditional Students also have these additional eligibility requirements:

Forms found on www.FHSAA.com (Parents Tab)

- **Homeschool students**
  - ***STUDENT MUST BE ZONED FOR TOHOPEKALIGA HIGH SCHOOL***
  - EL7 and EL7V Forms must be completed and submitted to the TKHS Athletics Department
  - Official Transcripts
- **Non-Member Private School**
  - ***STUDENT MUST BE ZONED FOR TOHOPEKALIGA HIGH SCHOOL***
  - EL12 and EL12V Forms must be completed and submitted to the TKHS Athletics Department
  - Official Transcripts
- **Alternative School Students - NEO CITY, OTECH, ZENITH ETC…**
  - GA4 and top portion of EL14

Registration Instructions for Parents

❏ Go to www.aktivate.com or scan the following QR code:

❏ 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 Aktivate or Register My Athlete in the past*)

❏ Fill in personal account information
(*This should be the Parent/Guardian personal information*)

❏ You will be using the site as a **Parent**

❏ Click **Create Account**

❏ Lastly, input the account **Verification Code** that you'll receive via email to confirm your account

Please Note: *You will need to open another tab (do not close your current tab) and find the verification email in your email inbox (it may take a few minutes to appear, so be patient). You can copy and paste the code into the pop-up or directly type into it.*

After you have an account:

❏ **Login**

❏ Under the Parents header, select "**Click here to start/complete athlete registrations**".

❏ Click **Start/Complete a Registration** (*upper left hand corner of the page*)

❏ Click **Start a New Registration** (*this is where you will enter all of your Athlete's information)*

❏ Follow the prompts to complete all requirements for your school's registration

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

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 4/23

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 4/23

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 4/23

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 #: _____

This page needs to be uploaded to Aktivate and submit original hard copy to TKHS Athletic Dept once completed

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 4/23

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 of Exam: ___ / ___ / _____

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.

This page needs to be uploaded to Aktivate and submit original hard copy to TKHS Athletic Dept only if referral was necessary

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 4/23

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 of Exam: ___ / ___ / _____

Address: _____ Phone: (_____) _____

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

Provider Stamp *(if required by school)*

This page needs to be uploaded to Aktivate and submit original hard copy to TKHS Athletic Dept once completed

THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA

Cardiology Report: Electrocardiogram (ECG) Finding

(to be completed by a licensed physician)

Parents: An ECG screen (also referred to as an EKG) can help identify young athletes who are at risk for sudden cardiac death, a condition where death results from an abrupt loss of heart function. An ECG screening may assist in diagnosing several different heart conditions that may contribute to sudden cardiac death. The School District is requiring one (1) cleared ECG, during a student's four (4) years of high school, to assure the health of any student participating in athletics.

Please have the reviewing physician fill out and sign this form and return to: _____ (Name of School)

Date: _____

Student's Name: _____

Sex: _____ Date of Birth: _____ Age: _____ Ethnicity: _____

Height: _____ Weight: _____

ECG in office:

Normal: _____ Abnormal: _____

Cardiac Clearance

Name of Physician or Approved Health Care Professional Date: _____

_____ _____

(Print Name) (Signature)

Address: _____ City / St _____ Zip _____

Comments:

_____

_____

_____

This page needs to be uploaded to Aktivate once completed

THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA

2023-2024 SCHOOL YEAR	MEDICAL AUTHORIZATION FORM Athletic Department	2023-24 SCHOOL YEAR

Student's Name: _____ **Grade**: _____ **DOB**: ___/___/____

I, the undersigned parent/guardian, in the event that I cannot be reached and/or the team is out of the county during an interscholastic event, do hereby authorize the designated SDOC coach or other emergency personnel, if it is deemed necessary, to transport my child to the nearest appropriate healthcare facility and obtain any necessary medical treatment. **This authorization is valid for the 2023-24 school year.**

I further understand that the School Insurance Policy does not guarantee policy benefits. The Student Insurance policy is secondary to all other sources of coverage and may not pay 100% for all incurred medical expenses. Any and all expenses and liability for said expenses incurred as a result of this medical treatment shall be fully assumed by me.

Claim information or eligibility contact: School Insurance of Florida - Policy # 09-0142-2024 (Expires June 30, 2024) P.O. Box 784268, Winter Garden, FL 34778-4628. Phone: 407-798-0290; Fax: 407-798-0296.

In order for you to receive the maximum insurance benefits, for which you are entitled, you MUST use your primary insurance network. Contact your insurance company prior to seeking ongoing treatment for an injury.

Food/ Medication Allergies: _____

_____

Special Medical Conditions: _____

_____

Insurance Company / Policy Number: _____

_____

Date of Last Tetanus Shot (If known): _____

_____ _____

Signature of Parent / Guardian **Phone Number(s)**

_____ _____

Witness (Must be of legal age) **Print Name**

ADDITIONAL EMERGENCY CONTACT INFORMATION

_____ _____

Print Name / Relationship to Child **Phone Number(s)**

_____ _____

Print Name / Relationship to Child **Phone Number(s)**

ImPACT Instructions

ImPACT Baseline Test

ImPACT is a computer-based neurocognitive testing tool used in the management of mild traumatic brain injury, commonly known as concussions. You are being asked to take a baseline test, so that in the event you sustain a head injury with a mechanism that suggests a concussion, we may be able to evaluate/assess the severity of injury and the progress of your recovery.

It is in your best interest to produce an honest effort in taking this baseline test, such that we have a valid baseline with which to measure in the event of a head injury. If you do poorly or produce a test with invalid results, you will need to retake the baseline test. Additionally, we will be required to manage your care in a much more careful approach, likely leading to a greater loss of participation time in the event of a head injury.

Instructions:

1. Be sure to take the ImPACT test in a quiet environment, free from distractions. Silence or turn off cell phones while taking the test.
2. You should not do any physical activity for 3 hours prior to the test.
3. Login to the computers. **Use Google Chrome on a desktop computer or a laptop.** You may use the school-issued laptops. **You cannot use a mobile device/tablet to take the ImPACT test.** Make sure to turn off pop up blockers.
4. Go to https://www.impacttestonline.com/testing
5. Enter Customer Code: **VJKB2EXW6D**
6. Click on "Launch Baseline Test." Follow the prompts and questions.
    a. Please complete all areas in the demographic section (i.e. what sport(s) you play).
    b. The years of school completed is not the grade you are currently in. This refers to all the years of school *completed*, not including kindergarten. Example: If you are in 11th grade, you have completed 10 years of education.
    c. Current level of participation should be high school. Years of experience refers to how many years you have been playing your sport in high school.
    d. If the system won't let you continue, there is something wrong, such as a wrong date
    e. Be sure to indicate whether you are using a trackpad (laptop without a mouse) or a mouse.
7. Once you complete the demographics section you will complete the test.
8. After test completion the last page asks to print out or email the confirmation… **Please print out the confirmation page and turn it in to the Athletic Deparment with your physical paperwork.** If you cannot print, please see the athletic trainer to verify test completion.