ALL portions must be completed and submitted as a packet by May 6th to Staff Sergeant Patterson.

Cadet Name: _____ **Current Grade:** _____
Last name, First name)

Applicant Checklist- for Staff Sergeant Use Only

- ❑ Physical
  - o Expiration Date: _____
- ❑ Student Code of Conduct Parent/Guardian Consent Form
- ❑ NJROTC Health Risk Screening Questionnaire
- ❑ NJROTC Standard Release Form
- ❑ Teacher Recommendation (e-mailed to pattersonla@nassau.k12.fl.us)
- ❑ Medical Authorization Form

Guidance:

GPA (9th – 11th Only): _____ **Attendance (percentage):** _____ **Tardies:** _____

School Counselor's Signature: _____

Admin/Dean:

Referrals:

- ❑ Yes
- ❑ No

ISS: _____ OSS: _____ Other: _____

Dean's Signature: _____

Accepted: _____ Rejected: _____ Initial: _____

JUNIOR RESERVE OFFICERS' TRAINING CORPS
STUDENT CODE OF CONDUCT AND PARENT/GUARDIAN CONSENT FORM

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 102, Junior Reserve Officers' Training Corps; DoD Instruction 1205.13, Junior Reserve Officers' Training Corps Program.

PRINCIPAL PURPOSE(S): To document you and your student's understanding of the expectations, responsibilities, and prohibitions related to participation in the Junior Reserve Officers' Training Corps (JROTC).

ROUTINE USE(S): Disclosure of records are generally permitted under 5 U.S.C. 522a(b) of the Privacy Act of 1974, as amended. To a Federal, state, or local agency maintaining civil, criminal, or other relevant enforcement information or other pertinent information, such as current licenses, if necessary to obtain information relevant to a DoD Component decision concerning the hiring or retention of an employee, the issuance of a security clearance, the letting of a contract, or the issuance of a license, grant, or other benefit. Additional routine uses are listed in the applicable System of Records Notices:
Army, A0145-2 TRADOC: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569985/a0145-2-tradoc/
Navy, N01533-1: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-Component-Article-View/Article/570325/n01533-1/
Air Force, F036 AETC B: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-Component-Article-View/Article/569771/f036-aetc-b/

DISCLOSURE: Voluntary. However, failure to fully complete requested information may render student ineligible to participate in the JROTC program.

PURPOSE

The Junior Reserve Officers' Training Corps (JROTC) Program is a world-class youth leader development program authorized by Congress and executed as a partnership between the Department of Defense, the military services and local School District High Schools. JROTC Instructors are retired service members and/or veterans employed as a faculty member by your local school district who are subject to the same laws, regulations and policies as other teachers within the District. A purpose of the JROTC is to instill in students in the United States secondary educational institutions the values of citizenship, service to the United States (including an introduction to service opportunities in military, national, and public service), and personal responsibility and a sense of accomplishment.

The purpose of this form is to share the expectations of the program, the expected behavior, and unacceptable behavior of all students and instructors taking part in the JROTC program. By initialling next to each statement, you acknowledge and agree to the expected/prohibited behavior explained in each section.

1. STUDENT NAME *(Last, First, Middle)*	2. PARENT/GUARDIAN NAME *(Last, First, Middle)*
3. JROTC UNIT/SCHOOL	**4. UNIT/SCHOOL ADDRESS** *(City, State, Zip Code)*
Navy National Defense Cadet Corps (NNDCC) Yulee High School	85375 Miner Rd Yulee, FL 32097

5. JROTC PROGRAM OFFICIAL *(Last, First, Middle)*
Patterson, Latoya Anika

6. EXPECTATIONS: I understand and acknowledge that:

(Initial Student/Parent or Guardian)

_____ / _____ a. Enrollment and participation in JROTC is purely voluntary. No representative of JROTC (adult or student), the school or school district, or other position of authority (including parents) may compel a student to participate in JROTC against their will. Students enrolled in JROTC may coordinate with their school representative to request withdrawal at any time for any reason per school policies.

_____ / _____ b. Inappropriate behavior between JROTC representatives/instructors and any student or minor, including JROTC participants, will not be tolerated. JROTC instructors are employees of the school/school district and are subject to the same high standards of professional conduct as other teachers. If I have any concern about inappropriate activities concerning either instructors or other students within the JROTC program, I will immediately notify high school administration and/or POCs identified in paragraphs 11 & 12.

_____ / _____ c. JROTC representatives/instructors shall:

c.1. Adhere to school policy where applicable with regard to entry of any students or unrelated minors into their dwelling without the written consent of the student's or minor's parent/guardian.

c.2. Adhere to school policy where applicable with regard to establishing a common household with a legally unrelated student or minor, that is, share the same living area in an apartment (does not include facilities open to all members of a homeowners' association or all tenants in an apartment complex), house, or other dwelling.

c.3. Adhere to school policy where applicable with regard to entry of any legally unrelated student or minor into privately owned vehicles. Exceptions are permitted for official business when the safety or welfare of a student or legally unrelated minor is at risk.

c.4. Adhere to school policy where applicable with regard to attending social gatherings, clubs, bars, theaters, or similar establishments on a personal social basis with a student or not legally related minor. Exceptions include inadvertent meetings at restaurants and other public places and inadvertent mutual attendance at other appropriate public places and events

7. COMPREHENSIVENESS & EXCEPTIONS:

The above list is not all inclusive and the Military Services may add additional prohibited activities. Prohibited activities between a JROTC instructor/ trainers and cadets listed in paragraph 6 apply from the first contact between an instructor and student through 6 months after student reaches the age of majority and/or is no longer affiliated with the JROTC program or enrolled in the high school, whichever is the latter date.

Exceptions may be granted to accommodate relationships that existed prior to the instructor's or student's JROTC affiliation. These relationships include, but are not limited to, family members. Any relations developing between JROTC representatives' family and the families of JROTC students must be declared to the school principal/school district representative. JROTC representatives wishing an exception must do so in writing to the appropriate school official and must include the JROTC student's parents/guardian's signature. Only high-level officials/authority, as designated by the host institution in consultation with the host service, has the authority to approve these exceptions. The unit will keep these documents on record while the student is enrolled in the program.

8. VIOLATIONS:

Violations of any part of paragraph 6.a through 6.14.iii, not granted an exception in paragraph 7, will result in a school or school district investigation, possible school or school district disciplinary action and possible JROTC instructor certification suspension or decertification. If at any time the student or parent/guardian are unwilling or unable to adhere to these expectations, the student may be removed from the JROTC program.

9. PARTICIPATION EXPECTATIONS AND STANDARDS: I understand and acknowledge that:

(Initial Student/Parent or Guardian)

_____ / _____ a. Initial and continued enrollment and participation in JROTC is incumbent on students understanding, acknowledging, and agreeing to adhere to expected standards and procedures.

a.1. Grooming/Personal Hygiene: JROTC students may be expected to adhere to the grooming standards of their affiliated Service while participating in JROTC activities. Accommodations, as agreed upon by both the school and JROTC representatives, may be made for religious or other specific situations. Students otherwise unable or unwilling to conform to the grooming standards may be removed from the JROTC program.

a.2. Uniform: JROTC students may be expected to wear variations of their affiliated Service's uniforms. Students participating in JROTC understand proper wear of uniforms is an integral part of the JROTC experience and agree to adhere to prescribed standards. Certain situations may require students wear "appropriate" civilian attire in lieu of standard uniforms which will be considered the prescribed uniform. Students not possessing suitable attire, should immediately notify their JROTC instructor and school representative of the situation.

a.3. Physical Fitness: Students enrolling in JROTC should expect to participate in activities that demand varying physical levels. Students requiring physical accommodations must ensure both the school and JROTC representatives are aware of the requirement and agree upon the appropriate accommodation. Per school policy, physical activities may require an athletic or similar medical/physical exam and clearance before students are allowed to participate.

a.4. Hazardous Activities: Some of JROTC's elective activities may involve hazardous environments. These include but are not limited to rifle/pistol/ archery ranges, obstacle courses, and high/low rope courses. Parents are required grant permission for their child's participation using school/school district procedures. Voluntary participation/nonparticipation does not impact students' overall JROTC standing.

10. PHOTO RELEASE:

This consent form requests permission to use your child's photo/image and name for Junior ROTC advertising purposes to include on social and other media. Please check one of the following choices:

☐ I GRANT permission for my child's photos/images and name to be used for Junior ROTC advertising purposes to include on social and other media.

☐ I GRANT permission for photos/images of my child without any other personal identifiers to be used for Junior ROTC advertising purposes to include on social and other media.

☐ I DO NOT GRANT permission for photos/images of my child to be used for Junior ROTC advertising purposes to include on social and other media.

11. KNOW YOUR RIGHTS:

Title IX is a federal law that was passed in 1972 to protect all students, faculty, staff, and employees from sex discrimination. Some of the specific prohibited actions:

- stalking or obscene phone calls, texts, emails, or gestures.
- sexually suggestive jokes, whistles, catcalls, or innuendos.
- inappropriate touching.
- intimidation.

Title IX also protects individuals from retaliation for filing a complaint of sexual misconduct or participating in an investigation.
Title IX requires School Districts to provide Title IX Coordinators in each school. You should receive Title IX education on an annual basis to ensure you are fully aware of the law. In the event you are a victim of or become aware of a Title IX violation you should contact your school's Title IX Coordinator as soon as practical. They are for your counsel and protection.

School/District Title IX Office:	
Name of Title IX Coordinator: Phone Number: Email Address:	**Department of Education Office of Civil Rights (OCR)** OCR@ed.gov or 800-421-3481, TDD 800-877-8339

12. POINTS OF CONTACT:

Affiliated Service JROTC Office:	**Air/Space Force IG:** **(800) 538-8429** saf.ighotline@us.af.mil
Navy Service Training Command, NJROTC Program 320A Dewey Ave Bldg 3 Room 106 Great Lakes, IL 60088-2912	**Inspector General (IG) Offices** **Army IG:** **(800) 752-9747** https://ig.army.mil/REQUEST-IG-ACTION/Request-Army-IG-Action/ **Coast Guard IG:** **(800) 323-8603** https://hotline.oig.dhs.gov/#step-1 **Marine Corps IG:** **(866) 243-3887** orgmb.igmc.hotline@usmc.mil **Navy IG:** **(800)522-3451** NAVIGHotlines@navy.mil **Department of Defense (DoD) IG:** **(800)424-9098** https://www.dodig.mil/rechot/

13. ACKNOWLEDGED BY: By signing below, I certify I have reviewed this form and acknowledge that I have read and understand this policy.

a. STUDENT NAME *(Last, First, Middle)*	**b. GRADE LEVEL**
c. DATE SIGNED *(YYYYMMDD)*	**d. SIGNATURE**
e. PARENT/GUARDIAN NAME *(Last, First, Middle)*	**f. PHONE/EMAIL**
g. DATE SIGNED *(YYYYMMDD)*	**h. SIGNATURE**
i. JROTC REPRESENTATIVE NAME *(Last, First, Middle)* Patterson, Latoya A (Staff Sergeant/USMC)	**j. POSITION** NNDCC Instructor
k. DATE SIGNED *(YYYYMMDD)*	**l. SIGNATURE**

INSTRUCTIONS FOR COMPLETING DD FORM 3203

1. STUDENT NAME. Enter the appropriate information of the student participant.

2. PARENT/GUARDIAN NAME. Enter the appropriate information of the Parent or Legal Guardian of the participant.

3. JROTC UNIT/SCHOOL. Enter the host institution's name and the JROTC Unit (Name/Number).

4. UNIT/SCHOOL ADDRESS. Enter the address of the host institution where the JROTC unit will take place.

5. JROTC PROGRAM OFFICIAL. Enter the appropriate information of the JROTC Program Official at the host institution.

6. EXPECTATIONS.

a) VOLUNTARY ENROLLMENT: Student and Parent/Guardian initials certify that the signees understand and agree to all statements within this section.

b) INAPPROPRIATE BEHAVIOR: Student and Parent/Guardian initials certify that the signees understand and agree to all statements within this section.

c) EXPECTED BEHAVIOR: Student and Parent/Guardian initials certify that the signees understand and agree to all statements within this section.

7. COMPREHENSIVENESS & EXCEPTIONS. The expectations of the Program should comprehensively align with appropriate behavior of the program representatives.

While the list of statements included on this form are not all inclusive of appropriate and expected behavior, actions similar in sentiment should be adhered to as well. JROTC Program representatives (instructor and/or student) should direct any questions on appropriate behavior to their School or School District Authority.

8. VIOLATIONS. Read the statement on violations. Your signature on this form certifies you understand and agree to this statement.

9. PARTICIPATION EXCEPTIONS AND STANDARDS. Enrollment in the JROTC program includes certain participation expectations. Read each statement and initial at the top of this section. Your initials certify you understand and agree to the statements within this section.

10. PHOTO RELEASE. Read the statement related to the use of the student's photo/image and name. Select the option that best aligns with your wishes.

11. KNOW YOUR RIGHTS. Read the statements included in this section related to your rights under Title IX. This section also provides guidance and a Point of Contact for reporting violations within your School District, as well as a Point of Contact at the Department of Education.

12. POINTS OF CONTACT. Participants are provided phone numbers and email addresses at each host military service as well as the Department of Defense (DoD).

13. ACKNOWLEDGED BY. Entering the appropriate information, and signing the fields below certifies that you have read and understood the information provided on this form and you agree to the statements included within.

a) STUDENT NAME: As stated.

b) GRADE LEVEL: Enter the student's grade level in high school for the current year of participation in the program.

c) DATE SIGNED: As stated.

d) SIGNATURE: Signing this document certifies that you have read, understand and agree to the statements included in this form.

e) PARENT/GUARDIAN NAME: As stated.

f) PHONE/EMAIL: Enter the appropriate information of the Parent/Guardian.

g) DATE SIGNED: As stated.

h) SIGNATURE: Signing this document certifies that you have read, understand and agree to the statements included in this form.

i) JROTC REPRESENTATIVE NAME: To be completed by the JROTC Instructor - Enter the appropriate information of the JROTC Instructor.

j) POSITION: Enter the appropriate title held within the JROTC Program. (Ex.: Senior Instructor, Assistant Instructor).

k) DATE SIGNED: As stated.

l) SIGNATURE: The Program Official's signature certifies that the DD Form 3203 is correct and complete and recommends approval.

NJROTC HEALTH RISK SCREENING QUESTIONNAIRE

Cadet Name: _____(Printed Name)

NJROTC Unit: _____High School

Date of your most recent pre-participation sports physical examination_____

Part A – TO BE COMPLETED BY THE CADET AND PARENT/GUARDIAN

Directions: Please answer Yes or No to the following questions: (Do not leave any questions blank)

1.	Do you have difficulty doing strenuous (great effort) exercise?	☐ Yes ☐ No
2.	Have you been told **NOT** to participate in long distance runs, such as a 1-mile-run?	☐ Yes ☐ No
3.	Have you been told **NOT** to do curl-ups or push-ups by a physician or other medical professional?	☐ Yes ☐ No
4.	Do you exercise less than three times per week for at least thirty minutes?	☐ Yes ☐ No
5.	Have you had any broken bones or a serious accident in the last three months?	☐ Yes ☐ No
6.	Do you use tobacco of any kind?	☐ Yes ☐ No
7.	Have you experienced chest, neck, jaw or arm discomfort while doing physical activity?	☐ Yes ☐ No
8.	Do you have asthma or are you using an inhaler to aid in breathing?	☐ Yes ☐ No
9.	Do you experience any shortness of breath with relatively low levels of exercise or exertion?	☐ Yes ☐ No
10.	In the last month have you felt any chest pain at rest?	☐ Yes ☐ No
11.	Do you have any known cardiac (heart) disease?	☐ Yes ☐ No
12.	Do you think you are overweight?	☐ Yes ☐ No
13.	Do you have dizzy/fainting spells, frequent headaches, or frequent back pains?	☐ Yes ☐ No
14.	Have you ever experienced dehydration after strenuous physical exercise?	☐ Yes ☐ No
15.	Are you currently under treatment by a physician or other medical practitioner?	☐ Yes ☐ No
16.	Has your mother or sister died without any explanation or suffered a heart attack before the age of 55?	☐ Yes ☐ No
17.	Has your father or brother died without any explanation or suffered a heart attack before the age of 45?	☐ Yes ☐ No
18.	Do you have high blood pressure or are you on blood pressure medication?	☐ Yes ☐ No
19.	Has a doctor ever told you that you have high cholesterol or are you on cholesterol medication?	☐ Yes ☐ No
20.	Do you have sugar diabetes?	☐ Yes ☐ No
21.	Have you experienced episodes of rapid beating or fluttering of the heart?	☐ Yes ☐ No
22.	Do you suffer from lower leg swelling of both legs?	☐ Yes ☐ No
23.	Do you have difficulty breathing or have sudden breathing problems at night?	☐ Yes ☐ No
24.	Do you have any personal history of metabolic disease (thyroid, renal, liver)?	☐ Yes ☐ No
25.	Do you have a bone, joint, or muscle problem that prevents you from doing strenuous exercises?	☐ Yes ☐ No
26.	Have you unintentionally lost/gained more than 10 percent of your body weight since your last PFT?	☐ Yes ☐ No
27.	Have you ever been diagnosed with Sickle Cell Trait?	☐ Yes ☐ No
28.	Do you have a current prescription for epinephrine (or "epi" pen) for situational use?	☐ Yes ☐ No

If you answered yes to any question please continue to the second page.

Cadet Signature Date Parent/Guardian Signature Date

Cadet Name:

Part B – TO BE COMPLETED BY A LICENSED MEDICAL PRACTITIONER

If any of the answers to the questions above were **YES,** request that the following section be completed and signed by a licensed medical doctor or registered school nurse:

Significant clinical history and/or current medication and treatment regimen of the above cadet: (Use below as neccessary)

Recommended/released for participation in strenuous physical activities including the 1.0-mile-run? ☐ **Yes** ☐ **No**

Signature of Medical Practitioner Date

NAVAL JUNIOR RESERVE OFFICERS TRAINING CORPS (NJROTC) STANDARD RELEASE FORM

Date: _____

I, _____, being the legal parent/guardian of _____, a member of the Naval Junior Reserve Officers Training Corps, in consideration of the continuance of his/her membership in the Naval Junior Reserve Officers Training Corps and/or his/her acceptance for Naval Junior Reserve Officers Training Corps training, do hereby release from any and all claims, demands, actions, or causes of action, due to death, injury, or illness, the government of the United States and all its officers, representatives, and agents acting officially and also the local, regional, and national Navy Officials of the United States.

I hereby authorize personnel of the Department of Defense, Armed Forces, Public Health Service, or civilian physicians to render such medical and dental care as may be necessary and medically indicated in the case of my son/daughter/ward during his/her period of training, as is deemed necessary by a qualified practitioner.

I understand that care at a military medical facility for non-military dependents will normally be rendered on a temporary (emergency) basis only: if further care is indicated, the patient will be transferred to non-military care as soon as possible. Emergency care provided to cadets who are not military dependents at a military facility may be subjected to reimbursement, and I may be billed for the care provided. For Navy Medical Department facilities, such care is authorized by NAVMEDCOMINST 6320.3B.

My son/daughter/ward has been determined to have the following allergies:
He/she requires medication for the treatment of:

Below are listed other medical conditions which my son/daughter/ward is known to have, which would preclude or limit in any way his/her participation in physical exercise and athletic programs.
His/her physician is:
Name:
Address:
Telephone (include area code):

Initials _____

Medical Insurance Company *
Name:
Street:
City, State, Zip Code:
Policy/ID Number:
Telephone Confirmation Number: ( )

Dental Insurance Company*
Name:
Street:
City, State, Zip Code:
Policy/ID Number:
Telephone Confirmation Number: ( )

***This insurance is not required. However, the information provided may be required to obtain non-emergency care.**

PRIVACY ACT NOTIFICATION

Under the authority of 5 U.S.C. Sec. 301, the information regarding your child's/ward's health, medical condition and treatment is requested in order to verify any need to administer medication and to enable medical/dental personnel to diagnose and treat any emergency condition which may arise during training. Pursuant to the Privacy Act, 5 U.S.C. Sec. 552, the requested information will not be divulged without your written authorization to anyone other than NJROTC area personnel involved with administration of NJROTC activities and medical/dental personnel requiring the information in order to effectively treat any medical/dental problem which may arise. Disclosure is voluntary: however, failure to provide the requested information will preclude your child's/ward's participation in the training.

Signature of Parent or Guardian:		
Address:		
City:	State:	Zip:
Telephone (include area code):		

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 3/24

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 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 catecholaminergic 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 3/24

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: ___/___/___

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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 signed below.

EL2

Revised 3/24

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 ever taken performance changes, [illegible]

☐ 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 #: _____

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SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

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

EL2

Revised 3/24

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: (____) _____

The preparticipation physical evaluation must be administered by a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with the practitioner's regulatory board. (§1006.20(2)(c), F.S.)

☐ 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, 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 #: _____

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.

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Nassau County School District

Medical Authorization Form

_____ (Student's Name) has my permission to participate in extra-curricular activities sponsored or authorized by Yulee H.S. – NNDCC School and/or the School Board of Nassau County.

In my absence or in the absence of an authorized parent or guardian of the Participant, I hereby authorize The School Board of Nassau County, Florida, its agents, servants, employees or designees to administer first aid and to obtain and consent to on behalf of the Participant and Participant's parents or guardians, any emergency first aid or medical care by any physician, hospital, or attendant which is deemed necessary or expedient by said physician, hospital or attendant as a result of involvement in the Activity. I agree to abide and be bound by such decisions and consents as if made by me and do assume full financial responsibility for and agree to pay all expenses of such care. I understand that it is my responsibility to secure adequate insurance for such first aid and medical care. The name of our health insurance company is _____ Policy Number _____.

I further authorize any physician, hospital or medical attendant to receive full and complete medical reports or information deemed necessary by them with respect to the treatment of my child. Execution of this document shall operate as an authorization for such person(s) to receive any medical information which they require.

The medical authorization contained within this form shall be valid and usable by The School Board of Nassau County during such periods of time as my child is enrolled in a school within said District and this authorization shall remain valid unless revoked by me in writing.

Parent or Guardian: _____ Date: _____

STATE OF _____ COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ by
(Date)

_____, who is personally known to me or who has
(Name of Person Acknowledged)

produced _____ as identification and who did (did not) take an oath.
(Type of Identification)

_____ _____
(Title or Rank) (Signature of Notary taking Acknowledgment)

_____ _____
(Serial Number,if any) (Name of Notary, typed,printed or stamped)

MIDDLE AND HIGH SCHOOL STUDENTS:

I hereby certify that I have read, understand and agree to abide by all of the rules of conduct and regulations of The School Board of Nassau County and if appropriate, the Florida High School Activities and Athletic Association. Any violation of these rules and regulations will subject me to disciplinary action.

Student's Signature: _____ Date: _____

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 3/24

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: _____ 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)*