2024-2025 BCHS Band Programs
Student Information and Fee Form
Please Complete One Form Per Student

We will not share personal information. Band Boosters use email regularly to communicate announcements and important updates via weekly newsletters. Please print clearly.

There is a $425 band fee for all <u>new</u> band members due prior to band camp. The fee covers (1) pair of shoes, (1) tights (auxiliary), (2) shirts, (2) mesh shorts. Tuba, Baritone, French Horn and Percussion Instruments are provided by the school, players will have an additional $50 instrument rental maintenance fee.

There is a $375 band fee for all <u>returning</u> band members due prior to band camp. The fee covers, (2) shirts, (2) mesh shorts. Tuba, Baritone, French Horn and Percussion Instruments are provided by the school, players will have an additional $50 instrument rental maintenance fee.

Student Last Name:____________________________**Student First Name:**______________________________

Student Nickname:________________________________ **Grade** (2024-2025) 9 10 11 12 **Student ID #**_________

Home Phone:____________________ **Student Cell:**____________________**Student Email**______________________

Student Primary Address:____

Mom/Guardian Name:__________ ______________________ **Mom/Guardian Cell:**__________________________

Dad/Guardian Name:__________________________________ **Dad/Guardian Cell:**___________________________

Mom Email:____________________________________ **Dad Email:**____

Concert Band Instrument:_______________________**Marching Band Instrument:**_________

Mandatory Freshman/New Band/Auxiliary Member Fee $425
Fee is non-refundable
Mandatory Returning Member Band/Auxiliary Fee: $375
Fee is non-refundable
**Tuba, Baritone, French Horn & Percussion (School Provided) Instrumental Rental/Maintenance Fee ($50)**$_________
Additional Shirts @ $15 each x _____ = $__________

Additional Shorts @ $10 each x ____ $ __________

TOTAL ENCLOSED: $___________

Shirt Size **Small** **Medium** **Large** **XLarge** **XXLarge** **XXXLarge**

Shorts Size **Small** **Medium** **Large** **XLarge** **XXLarge** **XXXLarge**

Checks should be made payable to BCHS Band Boosters. Please write student name in the memo line. Mail this form and payment to the address below or place in the lock box located in the band room.

Payments must be received by <u>May 24th</u>

BCHS Band Boosters
PO Box 111328, Naples, FL 34108

Barron Collier High School Cougar Band
Emergency Contact Information

Student Name (First & Last): ______________________________ **Current Year:** 9 10 11 12

Student ID Number: ____________________ **Student Cell Phone Number:** ____________________

Address: ____ **City/Zip:** ____________________

Mother's Name: ________________________ **Father's Name:** ________________________

Mother's Cell: ________________________ **Father's Cell:** ________________________

Please list 2 additional emergency contacts (other relatives, close family friends, or neighbors):

Contact #1 Name: ____________________ **Phone:** ________________ **Relation:** __________

Contact #2 Name: ____________________ **Phone:** ________________ **Relation:** __________

Family Doctor Name & Phone Number: ____________________ **Hospital Preference:** __________

Health Insurance Provider: ________________________ **Policy Number:** ____________________

Medication taken regularly: ____

Allergies: ____ **Is an EPI-PEN needed?** Yes No

Does the student have Asthma? Yes No **Inhaler Type & Use/Special Instructions:** ______________

Does the student have Diabetes? Yes No **Special Instructions:** ____________________________

Previous Concussions: __________________ **Previous Orthopedic Surgeries:** __________________

Previous injuries, illness, or other medical issues (Please be specific): ____________________

If this student is required to take medication during band camp or afterschool activities, I understand that I must complete the provided CCPS Medication Authorization Form and provided the required medication with the form to the school nurse.

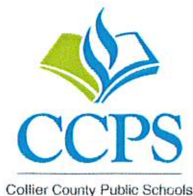
Collier County Public Schools are not responsible for any medical bills or ambulance services due to an athletic injury. I understand that my child will not be allowed to participate until coverage is provide by the parents/guardians. I understand that School Insurance is available for purchase and that forms are available at in the Activities Office.

In the event of serious accident or illness, I request that a representative of the school system contact me. If I cannot be reached, I request that contact be made with the emergency contacts or Primary Care Provider named and their instructions be followed in the treatment of my child.

If the emergency is such that immediate medical care is necessary, I authorize the school system to transport my child to a hospital for emergency care. The hospital, their agents, or a licensed physician, may administer such emergency medical treatment, as they deem necessary under the circumstances.

________________________ ________________________ __________

Parent/Guardian Name (Print) **Parent/Guardian Signature** **Date**



MEDIA RELEASE FORM
2024-2025 BCHS COUGAR BAND

We need parent permission to use a child's photograph, voice, and/or name in various media projects. Please read the following and check the box that applies to your consent.

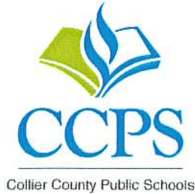
☐ **Yes – I consent.** I grant permission for my child to participate and appear in video or audio recordings, films, photographs, written articles, or on websites and social media sites. This consent includes the use and editing of my child's image, voice, and name in media projects by Collier County Public Schools (CCPS) to print, broadcast, Internet media outlets, such as newspapers, radio and television stations, and news websites. In consideration of the opportunity for my child to participate, I release Collier County Public Schools, including its employees and contractors, from all claims resulting from the use and editing of my child's image, voice, or name, and the use, sale, editing, and release to media outlets.

☐ **No – I do not consent** to the use of my child's photograph, voice and/or name in various media projects.

Your selection remains valid for all media projects occurring during the school year in which this form is signed. You may change your selection at any time by completing a new form at your school.

IN SIGNING THIS DOCUMENT, I UNDERSTAND THAT WHERE I HAVE CHECKED THE BOX "YES," I AM AUTHORIZING THE DISTRICT TO RELEASE INFORMATION THAT MIGHT OTHERWISE BE PROTECTABLE UNDER LAW.

______________________________	______________________________
Student Name (Please print clearly)	**Parent Name (Please print clearly)**
______________________________	______________________________
Student Signature	**Parent Signature**
______________________________	______________________________
Student ID#	**Date**



STUDENT TRAVEL AUTHORIZATION

COLLIER COUNTY PUBLIC SCHOOLS
Barron Collier High School Cougar Band 2024-2025

I, the undersigned parent/legal guardian of ________________________________,
(Name of Student)

grant permission for my child/ward to travel to ALL 2024-2025 BCHS Band & Auxiliary Activities sponsored by Barron Collier High School.

I understand the students are scheduled to depart and return to and from the school on the dates and times listed on the 2024-2025 BCHS Band Calendar found on the BCHS Band Website at www.bchsband.org.

I understand, acknowledge, and agree that: The School Board of Collier County, Florida will provide for reasonable supervision of students within its care and control. The supervision will be consistent with the ages of the students. However, the School Board is not an insurer of the safety of the student, nor can it supervise all movements of all students at all times.

In addition, there are certain risks inherent in travel and at the destination. I further understand that an employer or volunteer has no personal liability unless he or she has acted recklessly, wantonly, or intentionally to injure my child.

I understand that if I wish to request alternate travel accommodations for my student to a sponsored band event, an Alternate Travel Request Form must be turned in to Mr. Robinson at least 3 days prior to the event.

____________________ ____

Date **Parent/Legal Guardian Name (PRINTED)**

____

Parent/Legal Guardian Signature

Heat-Related Illness Guidelines & Information

Heat-Related Illnesses Information

People suffer heat-related illness when their bodies cannot properly cool themselves by sweating. Sweating is the body's way of cooling itself, but when a person's body temperature rises rapidly, sweating is not enough. Heat-related illnesses can be serious and life threatening. Very high body temperatures may damage the brain or other vital organs, and can cause disability and even death. Heat-related illnesses and deaths are preventable.

Heat Stroke is the most serious heat-related illness. It happens when the body's temperature rises quickly and the body cannot cool down. Heat Stroke can cause permanent disability and death.

Heat Exhaustion is a milder type of heat-related illness. It usually develops after a number of days in high temperature weather and not drinking enough fluids (water). Heat Cramps usually affect people who sweat a lot during demanding activity. Sweating reduces the body's salt and moisture and can cause painful cramps, usually in the abdomen, arms, or legs. Heat cramps may also be a symptom of heat exhaustion.

Young and healthy individuals can succumb to heat if they participate in demanding physical activities during hot weather. Other conditions that can increase your risk for heat-related illness include obesity, fever, dehydration, poor circulation, sunburn, and prescription drug or alcohol use.

Symptoms of heat-related illness may include:

- Fainting (Unconsciousness)
- Throbbing headache
- Dizziness and light-headedness
- Lack of sweating despite the heat
- Red, hot, and dry skin
- Muscle weakness or cramps
- Nausea and vomiting
- Rapid heartbeat, which may be either strong or weak
- Rapid, shallow breathing
- Behavioral changes such as confusion, disorientation, or staggering
- Seizures

PARENTAL/GUARDIAN CONSENT TO PARTICIPATE AND RELEASE FROM LIABILITY

I hereby give my consent for my child, as a Collier County School District ("the District") high school student, to participate in District music performance assessments, extracurricular, or co-curricular music activities (including marching band, color guard, drum line, and so on). I and my child have reviewed the Florida School Music Association (FSMA) Rules and Regulations pertaining to eligibility (available at www.flmusiced.org under FSMA Rules and Regulations). I and my child recognize that he/she must follow all District policies, rules, and procedures, including the Code of Student Conduct.

In providing consent, I am aware of the risks involved in such participation. We both understand that injury, including the potential for a concussion head-related illness, of any other injurious events, is possible in such participation, and choose to accept the risks involved. I voluntarily accept any and all responsibility for my child's safety and welfare while participating in these activities, with full understanding of the risks involved. Accordingly, I hereby release and hold harmless the District School Board, its employees and agents, the adjudicators of the sanctioned event from any and all responsibility and liability for any injury or claim arising from such participation and agree to take no legal action a against the District because of any accident or mishap involving my child's participation.

In this regard, I authorize the District to review all academic records relevant to my eligibility including, but not limited to, my records relating to enrollment and attendance, age, discipline, finances, residence, and physical fitness. I also authorize the use or disclosure of all health information relating to my child should treatment for illness or injury become necessary. This shall include emergency medical treatment for my child should the need arise for such treatment while my child is under the supervision of the District with respect to participating in the activities noted above. Finally, if I have knowledge about the risk of continuing to participate if such an injury is sustained without proper medical clearance, I will inform the District accordingly, as well as, of any other underlying medical condition of which I am aware.

______________________________ ______________________________

Name of Parent/Guardian (Printed) Signature of Parent/Guardian

Date:__________________

______________________________ ______________________________

Name of Student (Printed) Signature of Student

Date:__________________

2024-2025 BCHS Band Programs

Band Booster Membership Form

The Barron Collier High School Band Boosters Organization is dedicated to the continued success of the Barron Collier High School band programs and hopes through its efforts to be able to assist in providing a rewarding music education opportunity to the students of Barron Collier High School. Membership is strongly encouraged for all band and auxiliary parents. It allows you to chaperone events, vote in booster meetings, and support the organization that is focused on your student! Booster membership lasts for one academic year.

Parent Name(s): ____

Parent E-mail(s): ____

Parent Preferred Contact Number:
(Please circle) Home or Cell ____________________________________

Band Student Name(s): ____

____

Booster Membership is $30 per household.

Please complete form and submit with a check payable to "BCHS Band Boosters". Students can drop off form and payment to the lockbox located in the band room.

Administrative Use: Cash _____; Check_______; Date ____________; Initials________

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 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 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: ___/___/___

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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 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 #: ________

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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.

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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)*