

**2025-2026 FHSAA Physical Packet**  
**Cypress Creek Middle School**  
**6<sup>th</sup>-8<sup>th</sup> Grade**

\*The FHSAA physical packet for the 2025-2026 school year must be completed using [www.athleticclearance.com](http://www.athleticclearance.com). Instructions for uploading the necessary documents are enclosed in this packet. Please see the list below for items that will need to be uploaded prior to clearance being granted.

Paperwork Requirements:

- FHSAA EL2 w/ Doctor, Parent, and Student Signatures, Exam Date, and Office Stamp. (Page 4)
- NFHS Concussion in Sports Certificate
- NFHS Heat Illness Certificate
- NFHS Sudden Cardiac Arrest Certificate
- Transportation Release Form

Eligibility Requirements:

- CCMS Zoned/Approved School Choice Full Time Student
- Home School/FLVS Student Zoned for CCMS
- Full-Time Pasco eSchool Student that Resides in Pasco County
- 2.0+ GPA from Previous Semester

## Online Athletic Clearance

1. Visit [AthleticClearance.com](https://AthleticClearance.com). Click on the Florida Picture
2. Click on **"Create an Account"** and follow steps. Or Sign in if you have previously created an account. Watch tutorial video if help is needed.
3. **Register**. PARENTS register with valid email username and password
4. Login using your email address that you registered with
5. Select **"Start Clearance Here"** to start the process.
6. Choose the School Year in which the student plans to participate. *Example: Football in August 2025 would be the 2025-2026 School Year.*  
Choose the School at which the student attends and will compete for.  
Choose Sport. \*You can also "Add New Sport" if a multi-sport athlete. Electronic signatures will be applied to the additional sports/activities.
7. Complete all required fields for Student Information, Educational History, Medical History and Signature Forms. **(If you have gone through the AthleticClearance.com process before, you will select the Student and Parent/Guardian from the dropdown menu on those pages)**
8. Once you reach the **Confirmation Message** (if your school uses it) you have completed the process.
9. All of this data will be electronically filed with your school's athletic department for **review**. When the student has been **cleared for participation**, an email notification will be sent.

## Online Athletic Clearance FAQ

### What is my Username?

Your username is the email address that you registered with.

### Multiple Sports

On the first step of the process, you have the ability to "Add New Sport". If you use this option, you fill out the clearance one time and it is applied to the sport selected.

If you complete a clearance and come back at a later date to add a sport, you will "Start New Clearance" and then autofill student and parent information using the dropdown menus on those pages.

### Physicals

The physical form can be downloaded on Files page. Most schools will accept the physical upload as well as turning in a hard copy to the athletic department.

### Why haven't I been cleared?

Your school will review the information you have submitted and Clear, Clear for Practice or Deny your student for participation. You will receive an email when the student's status is updated.

### My sport is not listed!

Please contact your school's athletic department and ask for your sport to be activated.

Questions? Go to [Support.AthleticClearance.com](https://Support.AthleticClearance.com) and submit a ticket.

Click Start Clearance Here

2. Select 2025-2026
3. Select Cypress Creek Middle
4. Select Sports you are trying out for in 2023-2024. If you are trying out for multiple sports, Click Add New Sport and add ALL sports you are anticipating trying out for. Click Next, which will take you to the Student Information Page.
5. Student Information Page – Use the Drop-Down Menu under Choose Existing Student to select the student you are registering. Student Information will Populate.
  - a. Enter Students Grade
  - b. Select Whether Student is Covered by Insurance (Insurance Information from previous year will save, make sure to confirm this correct)
  - c. Select Education History
  - d. Click Save & Continue to get to the Parent Information Page
6. Parent Information Page – Use the Drop-Down Menu under Choose Parent/Guardian to select the Parent/Guardian to populate the information.
  - a. Select who is Filling out this Form
  - b. Click Save & Continue to continue on to Medical History Page
7. Complete Medical History Information
8. Submit Signatures on Forms
  - a. Signatures have to be an EXACT match of what is entered into the Student Info & Parent Info pages.
9. Upload Files – Upload required Files. Your previous files are saved into your account. Click choose existing File to select files that you have uploaded to previous Clearances. If you have a new File to upload, click Browse and select it from your Computer/Phone
  - a. Click Submit Your Completed Registration

Questions? Go to [Support.AthleticClearance.com](https://Support.AthleticClearance.com) and submit a ticket.



## 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 of exam.

**EL2**

Revised 2/25

### 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 Questionnaire 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		Yes	No	HEART HEALTH QUESTIONS ABOUT YOU (continued)		Yes	No
1	Do you have any concerns that you would like to discuss with your provider?			8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
2	Has a provider ever denied or restricted your participation in sports for any reason?			9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
3	Do you have any ongoing medical issues or recent illnesses?			10	Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No
4	Have you ever passed out or nearly passed out during or after exercise?			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)		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			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)?		
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
7	Has a doctor ever told you that you have any heart problems?						

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 of exam.*

**EL2**

Revised 2/25

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:

\_\_\_\_\_

\_\_\_\_\_

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**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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



**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 of exam.*

**EL2**

Revised 2/25

**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 experienced performance changes, felt fatigued, and/or experienced times of low energy during the past year?

- ☐ 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 <ul style="list-style-type: none"><li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li></ul>			
Eyes, Ears, Nose, and Throat <ul style="list-style-type: none"><li>Pupils equal</li><li>Hearing</li></ul>			
Lymph Nodes			
Heart <ul style="list-style-type: none"><li>Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)</li></ul>			
Lungs			
Abdomen			
Skin <ul style="list-style-type: none"><li>Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis</li></ul>			
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 <ul style="list-style-type: none"><li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li></ul>			

**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 #: \_\_\_\_\_

# Upload this Form



## 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 of exam.

**EL2**

Revised 2/25

### 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: (\_\_\_\_) \_\_\_\_\_

#### 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.

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction after clearance by medical specialist for: \_\_\_\_\_  
*(If this option is checked, additional medical follow-up and clearance prior to sports participation is required. Use EL2 Page 5 for documentation.)*

☐ Medically eligible for only certain sports as listed below:

☐ Not medically eligible for any sports

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

In accordance with §1006.20(2)(c), F.S., I hereby certify that I am a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with my regulatory board and 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 #: \_\_\_\_\_

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





## PREPARTICIPATION PHYSICAL EVALUATION (Supplement)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date of exam.

**EL2**

Revised 2/25

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)*





LEARNING  
CENTER

As per FHSAA Policies 40.1.1, 41.1 and 42.1.1, all student-athletes are required to watch the following FREE NFHS Learn courses annually.

- Concussion In Sports -- What You Need to Know
- Heat Illness Prevention
- Sudden Cardiac Arrest

### Course Ordering

Step 1: Go to [www.nfhslearn.com](http://www.nfhslearn.com).

Step 2: "Sign In" to your account using the e-mail address and password you provided at time of registering for an nfhslearn account.

OR

If you do not have an account, "Register" for an account.

Step 3: Click "Courses" at the top of the page.

Step 4: Scroll down to the specific course from the list of courses.

Step 5: Click "View Course".

Step 6: Click "Order Course."

Step 7: Select "Myself" if the course will be completed by you.

Step 8: Click "Continue" and follow the on-screen prompts to finish the checkout process. (Note: There is no fee for these courses.)

### Beginning a Course

Step 1: Go to [www.nfhslearn.com](http://www.nfhslearn.com).

Step 2: "Sign In" to your account using the e-mail address and password you provided at time of registering for an nfhslearn account.

Step 3: From your "Dashboard," click "My Courses".

Step 4: Click "Begin Course" on the course you wish to take.

For help viewing the course, please contact the help desk at NFHS. There is a tab on the upper right hand corner of [www.nfhslearn.com](http://www.nfhslearn.com). If you should experience any issues while taking the course, please contact the NFHS Help Desk at (317) 565-2023.



**DISTRICT SCHOOL BOARD OF PASCO COUNTY  
PARENT RELEASE**

MIS Form #166  
Rev. 01/18

**TRANSPORTATION BY:**

School Bus/Van\_\_\_\_Private\_\_\_\_Vehicle\_\_\_\_Walking\_\_\_\_Charter Bus\_\_\_\_PCPT\_\_\_\_

Date of Field Trip\_\_\_\_\_ Sponsor \_\_\_\_\_

In consideration of \_\_\_\_\_ having been accepted by the  
Student Name - Please Print Date of Birth

principal, teacher(s) or other personnel of \_\_\_\_\_ School of the District School

Board of Pasco County to go on a school sponsored trip to \_\_\_\_\_,  
and I, the undersigned, understand that my child, if transported by a privately owned vehicle, charter bus, school bus or walking, hereby release the District School Board of Pasco County, the individual members of said Board, the Superintendent, the principal, teachers or other employees of the school, and volunteer leaders from any financial responsibility because of sickness of the student while going to, returning from, or attending said field trip or because of any accident in which the student is injured. To ensure prompt attention in case of sickness or accident, I hereby authorize the person(s) in charge of said trip to incur expense considered necessary for treatment, and I agree to pay for same if this is in excess of the amount paid by any accident or health insurance policy that may be in effect at the time of the sickness or accident.

In any situation in which the safety and security of students might be compromised (e.g., Red Alert Status issued by the Department of Homeland Security, severe weather conditions, etc.) the District School Board of Pasco County will take the necessary steps to ensure the safety of its students and staff, including the cancellation of scheduled field trips and school events. Should this trip or event be cancelled as a result of such an event, the District cannot guarantee any monies (including deposits) will be refunded by the vendor(s) associated with this transaction. Therefore, students, parents, guardians, etc., are hereby cautioned and advised that the District will not be liable for any reimbursements associated with this event that are not refunded by the vendor(s) and returned to the District.

I have documented below all precautions/instructions regarding my child's medication. I have noted any special health related conditions or allergies regarding my child. I understand that the trained school employee who usually dispenses medication may or may not be present during the trip. Medications will be dispensed by a trained school employee (in accordance with Board Policy 5330).

Please list any medication(s) your child is currently taking (at home or school): (Dosages/Times)

\_\_\_\_\_  
Allergies:\_\_\_\_\_Additional Health Concerns: \_\_\_\_\_

Name of Parent or Guardian – Please Print			Date
Signature of Parent or Guardian	Primary Phone	Alternate Phone	Business Phone
Street, Rural Route, or P.O. Box			
City	State	Zip Code	
Name of Additional Emergency Contact / Relationship to Student			Phone