

Aktivate Formerly Registermyathlete.com

Registration for Parents

- Go to www.aktivate.com - effective 4-17-23
- Click Login
- Click Create an Account (You only need ONE account, even if you have children in more than one high school and/or junior high; Do Not create another account if you have used Register My Athlete in the past)
- Fill in personal account information (**this should be the Parent's personal information**)
- You will be using the site as a Parent
- Click Submit

After you have an account:

- Login
 - Under the Parents header (Blue), Click the button labeled "Click here to start/complete athlete registrations". (the first time you log in you will be asked to agree to terms and conditions)
 - Click Start/Complete a Registration (upper left hand corner of the page)
 - Click Start a New Registration - **this is where you will enter all of your Athlete's information**
 - Click on the red bars to complete all requirements
 - Click the orange button on the lower left side of the screen for live chat
- or email support@aktivate.com for assistance

* Forms are labeled on the top right,
They are for a ① PARENT
OR
② DOCTOR

THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA
1960 LANDINGS BOULEVARD, SARASOTA, FL 34231
PHONE (941) 927-9000

**PARENT/GUARDIAN RELEASE AND HOLD HARMLESS AGREEMENT FOR
HIGH SCHOOL STUDENT ATHLETIC PARTICIPATION**

Instructions: This form must be notarized and returned to the Head Coach/Athletic Director's Office with the Athletic Packet. If you have questions pertaining to this form, contact your child's school.

Student Name (Print) _____ Student No. _____ DOB _____

School Name _____ School Year _____

Name of sport/activity this agreement governs _____

Parent/Guardian Home Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

I/We fully understand that playing or practicing to play interscholastic sports may be hazardous and poses a risk of injury, including but not limited to, sprains, strains, contusions, abrasions, broken bones and in extreme cases, paralysis or death. Due to the potential hazards associated with interscholastic sports, I/we recognize the importance of following the instructions of coaches and trainers, regarding playing techniques, training and other rules associated with this sport/activity.

I/We understand that it is the responsibility of the parents/guardians to provide proof of medical insurance coverage prior to participating in any phase of this sport/activity.

- Yes I/we will be purchasing the student accident insurance made available through the Sarasota School District.
- No I/we have comprehensive medical insurance that covers this student for any expenses he/she may incur as the result of a sports injury.

Insurance Company Name _____

Policy No. _____ Effective Dates _____

This agreement is entered into voluntarily and is made with the understanding that I/we have not violated any of the eligibility rules and regulations of the Florida High School Athletic Association (FHSAA) and/or the Sarasota School District. I/we give my/our consent for my/our student/child/ward to engage in FHSAA and Sarasota School District approved athletic activities as a representative of the student's school. I/we give my/our consent for him/her to accompany the team on out of town/county trips.

In consideration of The School Board of Sarasota County, Florida, permitting my/our student/child/ward to engage in interscholastic sports, I/we agree to release and hold harmless The School Board of Sarasota County, Florida, and its employees and agents from and against all claims, judgments, cost, expenses, attorney fees, including but not limited to, claims occurring from the negligence of The School Board of Sarasota County, Florida, its employees, and agents arising out of bodily injuries or property damage resulting from participation in interscholastic sports.

I/We acknowledge that I/we have read this agreement and fully understand its meaning, and that I/we will abide by all terms and conditions associated with this sport/activity and in this agreement.

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date _____

Student Signature _____ Date _____

STATE OF FLORIDA, SARASOTA COUNTY

Sworn to (or affirmed) and subscribed before me by means of physical presence or online notarization, this _____ day of _____, 20____, by _____ who is

Personally Known Produced Identification Type of Identification Produced _____

(Seal)

Typed or Printed Name of Notary Public

Signature of Notary Public

My Commission Expires _____ Commission No. _____

THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA
1960 LANDINGS BOULEVARD, SARASOTA, FL 34231
PHONE (941) 927-9000

RELEASE FOR OUT-OF-COUNTY OR OVERNIGHT TRAVEL FOR ATHLETICS AND FIELD TRIPS

Instructions: Form must be signed and notarized and returned to child's school. If you have questions pertaining to this form, contact your child's school.

Student Name (Print) _____ Student No. _____ Student No. _____ DOB _____

Address _____ School Year _____

Home Phone _____ Parent/Guardian Work Phone _____ Cell Phone _____

Other Emergency Contact Name _____ Phone _____

Medical Insurance Carrier _____ Policy Group No. _____

This application to travel and participate in activities or events sponsored by the Sarasota County Schools is entirely voluntary on our part and is made with the understanding that we have not violated any of the eligibility rules and regulations of the Florida High School Athletic Association or the Sarasota County Schools. It is also agreed that we will abide by all the rules set down by the School Board of Sarasota County, the Florida High School Athletic Association, and the school.

The School Board of Sarasota County, its school principals and teachers, desire that students and parents or guardians of students have a thorough understanding of the implications involved in a student participating in a voluntary extracurricular activity or curricular field trips. For this reason, it is required that each student in the Sarasota County Schools, his/her parent, parents, or guardian, read, understand, and sign this agreement prior to the student being allowed to participate in any out-of-county or overnight school trip.

1. I/We, the undersigned, as parent, parents or guardians, give my/our consent for the student identified herein to participate in out-of-county or overnight travel as a representative of his/her school.
2. I/We, will not hold the School Board of Sarasota County, anyone acting in its behalf, or the Florida High School Athletic Association responsible or liable for any injury occurring to the named student in the course of such activities or such travel. I/We release the School Board of Sarasota County, its employees, and agents from all claims, including any claims, costs or damages arising from the negligence of the School Board of Sarasota County, its agents, or employees.
3. I/We understand that school officials will complete accident insurance forms, if the student has school insurance, after which all claims under insurance policy, or policies, for injuries received while participating in school events, shall be processed by the student, his/her parent, parents, or guardian through the company agent handling the student's insurance policy, and not through the school officials.
4. I/We hereby accept financial responsibility for equipment or instruments lost by the student identified herein.
5. I/We authorize the school to transport and to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for the student in the course of such activities or such travel. I/We also agree that the expenses for such transportation and treatment shall not be borne by the school district or its employees.
6. I/We accept full responsibility and hereby grant permission for my/our son/daughter to travel on any approved school related trip. **This statement remains in effect until the end of this school year unless cancelled by me in writing to the school.**

Student Signature _____ Date _____

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

State of Florida
County of Sarasota

Sworn to (or affirmed) and subscribed before me by means of physical presence online notarization, this _____ day of _____ 20____ by _____ (Name of Person Making Statement)

The foregoing instrument was acknowledged by _____ who is _____ personally know to me, or _____ produced identification/Type of Identification _____

Notary Public Signature _____ Name of Notary Public: Print, Stamp, or Type as Commissioned _____

My Commission Expires _____ Commission Number _____

PARENT



PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)
*This medical history form should be retained by the healthcare provider and/or parent.
 This form is valid for 365 calendar days from the date signed below.*

EL2
 Revised 3/23

MEDICAL HISTORY FORM

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

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ____/____/____
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ City/State: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____ Relationship to Student: _____
 Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
 Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

List past and current medical conditions:

Have you ever had surgery? If yes, please list all surgical procedures and dates:

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

Patient Health 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 Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.		Yes	No	HEART HEALTH QUESTIONS ABOUT YOU <i>(continued)</i>		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 signed below.*

PARENT

EL2
 Revised 3/23

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

BONE AND JOINT QUESTIONS		Yes	No	MEDICAL QUESTIONS (continued)		Yes	No
14	Have you ever had a stress fracture?			26	Do you worry about your weight?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			27	Are you trying to or has anyone recommended that you gain or lose weight?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?			28	Are you on a special diet or do you avoid certain types of foods or food groups?		
MEDICAL QUESTIONS		Yes	No	29	Have you ever had an eating disorder?		
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?			Explain "Yes" answers here: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____			
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?						

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: ___/___/___

Modified from © 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.



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.*

DOCTOR

EL2

Revised 3/23

PHYSICAL EXAMINATION FORM

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

PHYSICIAN REMINDERS:

Consider additional questions on more sensitive issues.

• Do you feel stressed out or under a lot of pressure?	• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Do you drink alcohol or use any other drugs?	• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	

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

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: Yes No
MEDICAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 		
Eyes, Ears, Nose, and Throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph Nodes		
Heart <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 #: _____

Modified from © 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.



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.

DOCTOR
EL2
 Revised 3/23

MEDICAL ELIGIBILITY FORM

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

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___/___/___
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ City/State: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____ Relationship to Student: _____
 Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
 Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

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

 - Medically eligible for only certain sports as listed below:

 - Not medically eligible for any sports
- Recommendations: *(use additional sheet, if necessary)*

I hereby certify that I have examined the above-named student-athlete using the FHSAA EL2 Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date: ___/___/___
 Address: _____ Phone: (____) _____
 Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp *(if required by school)*

PARENT
 ↓

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.

Modified from © 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.



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.

DOCTOR REFERRAL

EL2

Revised 3/23

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

MEDICAL ELIGIBILITY FORM - Referred Provider Form

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

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___/___/___
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ City/State: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____ Relationship to Student: _____
 Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
 Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

Referred for: _____ Diagnosis: _____

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

- Medically eligible for all sports without restriction as of the date signed below
- Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

Medically eligible for only certain sports as listed below:

Not medically eligible for any sports

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

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

Address: _____ Phone: (____) _____

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

Provider Stamp *(if required by school)*