TREASURE COAST HIGH SCHOOL
BAND PARTICIPATION / MEDICAL PERMISSION FORM

STUDENT NAME_____AGE _____
ADDRESS_____DATE OF BIRTH_____
PHONE #_____SOCIAL SECURITY #_____
PARENT OR LEGAL GUARDIAN NAME(S) WORK PHONE #(S)
_____

I, the undersigned parent or legal guardian of_____
Grant full permission to any physician or hospital to take any action deemed necessary in case of an accident or illness.

I, the undersigned parent of legal guardian agree to all policies as set forth in the Treasure Coast High School Band Handbook. I grant full permission for my child to be an active member of the Treasure Coast High School Band and to attend all required band functions.

(PARENT OR LEGAL GUARDIAN SIGNATURE) (DATE)
In Case of Accident or Illness notify:

NAME_____PHONE_____
NAME_____PHONE_____

List any prescriptions or medications your child takes on a regular basis:
_____

List any medications that your child is allergic to:
_____

List any special medical condition(s), allergy, or other problems your child may have:_____
_____

Physician Name: _____Phone: _____

INSURANCE COMPANY_____
POLICY #_____PHONE #_____
*****PLEASE ATTACH A COPY OF YOUR INSURANCE CARD*****

This document is correct to the best of my knowledge and the student described above has permission to engage in all activities unless otherwise noted above. I hereby grant permission for the supervising director to act “in loco parentis” in case an emergency arises if I, the parent/guardian, cannot be contacted.

_____
(PARENT OR GUARDIAN SIGNATURE) (DATE)
NOTARY STATEMENT…
Sworn to and subscribed before me this _____day of _____ 20____;

_____
NOTARY PUBLIC / STATE OF FLORIDA

_____
SEAL OF NOTARY

My Commission Expires:_____

ST. LUCIE COUNTY SCHOOL BOARD

Treasure Coast High School Band

ANTI-HAZING ACKNOWLEDGEMENT

The School District of St. Lucie County strives to maintain a healthy performing arts program in which all students feel safe and welcome. It is the goal of the district for students, parents and the community to be proud of the school and programs which they represent.

I understand that hazing of any kind is not allowed on this campus and in the athletic program. This includes mental, verbal, physical and any other act of harassment intended to demean another student. I further understand that it is my duty to report any such acts that I observe to a staff member on campus.

By signing below, I agree to uphold this policy and understand that any violation will result in my immediate suspension from athletics and consequences as prescribed in the St. Lucie County Schools Code of Student Conduct. Additionally, I understand that if Florida Statutes are violated that I will be subject to arrest.

_____ _____

Student Name Student Signature

_____ _____

Parent/Guardian Name Parent Guardian Signature

Definitions of Hazing

1. To persecute or harass with meaningless, difficult, or humiliating tasks.

2. To initiate, as into a high school team, by exacting humiliating performances from or playing rough practical jokes upon.

Treasure Coast High School
"Titan Band"
1000 SW Darwin Blvd, Port St. Lucie, FL 34953
Phone: (772) 807-4300

TCHS Band 2020-2021
Band Budget Agreement

I have read, understand, and accept the Treasure Coast High School Band Budget agreement for the 2019-20 school year. I also understand that by accepting and signing this Band Budget Agreement, I am responsible for payment of $100 for a band member. Students using school owned instruments are responsible for an equipment maintenance fee of $25.00 per semester (color guard only pays this for the fall semester).

I will make payments on or before the following dates or will fundraise the amount listed below:

Band Fair Share Payments:
7/27 (or when my child joined the program) = $100.00

Equipment Maintenance Fee Payments:
7/27 (or when my child began using school equipment for that semester) = $25.00
1/11 (or when my child began using school equipment for that semester) = $25.00

Color Guard Uniform Payments:
8/1 (or when my child joined the program) = $50.00

I will either raise the money through fundraisers or pay the amount when due from my own funds. I understand that failure to maintain an up to date account may cause my child to be placed on the school's obligation list. I also understand that the entire Band Program is dependent on the participation and support of instructors, students, and parents and that my financial obligation is an integral part of that support. Should I choose to leave the band, I am still obligated to my financial commitment unless the director and I come to other terms.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

Students who have unpaid balances may be withheld from after school concerts and/or performances, trips, band social activities, and their official high school diploma will not be released or forwarded until all outstanding fees have been paid in Full. Students with unpaid balance at the end of the fundraising activities will be placed on the school's obligation list

TREASURE COAST HIGH SCHOOL

BAND HANDBOOK

VERIFICATION FORM

STUDENT VERIFICATION

I have read the Treasure Coast High School Band Handbook and agree to adhere to the policies, rules and regulations established therein. I will forward questions directly to the director.

_____ _____

Student's Signature Date

(Do not separate)

PARENT VERIFICATION

I have read the Treasure Coast High School Band Handbook and agree to adhere to the policies, rules and regulations established therein. I will forward questions directly to the director.

_____ _____

Parent's Signature Date

Student ID # _____

Appendix B

Media Release Form

To publicize the achievements of the members of Treasure Coast High School Band, we like to occasionally publish news about their accomplishments and upcoming events.

Please fill out the form below to indicate your desire to include or exclude your child in media relations.

2020 – 2021 School Year

Student Name: _____

Grade: _____

_____ I consent to having my child's photo, name and/or achievements published in the school newspaper and/or newsletters, released to local newspapers or TV, and/or posted on the school's web page.

_____ I **DO NOT** want my child's photo, name, and/or achievements published in the school newspaper and/or newsletters, released to local newspapers or TV, and/or posted on the school's web page.

_____ _____

Parent Signature **Date**

Due Thursday, August 16, 2018

ST. LUCIE PUBLIC SCHOOLS

MEDICAL RELEASE FORM FOR OUT-OF-COUNTY OR OVERNIGHT TRAVEL

FOR BAND, CHEERLEADING AND OTHER NON-ATHLETIC EVENTS

School Year 2020-2021

Name of Student (Please print) _____

Address _____

Home Phone _____ Date of Birth _____ Place of Birth _____

Parent's work phone _____ Other Emergency Phone _____

This application to travel and participate in activities or events sponsored by St. Lucie Public 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 St. Lucie Public Schools. It is also agreed that we will abide by all the rules set down by the School Board of St. Lucie County, and the school.

The School Board of St. Lucie County, and 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 g in a voluntary extracurricular activity. For this reason it is required that each student in the St. Lucie 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 guardian, give my/our consent for the student identified herein to participate in this activity as a representative of his/her school.
2. I/We, will not hold the School Board of St. Lucie County, anyone acting in its behalf, or the Florida High School Athletics Association responsible or liable for any injury occurring to the named student in the course of such activities or such travel.
3. I/We understand that school officials will complete required accident insurance forms, 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 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 or 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 son/daughter to travel on any approved school related trip. This statement remains in effect until the end of this school year unless canceled by me in writing to the school.

----------Acknowledgment of Parent/Guardian Signature----------

Print Parent/Guardian Name _____Date _____

Sign Parent/Guardian Name (In presence of Notary) _____

STATE OF FLORIDA

COUNTY OF ST. LUCIE

The foregoing instrument was acknowledged before me this ___ day of _____ , _____, by _____. He/She is __ personally known to me, or __has produced _____ as identification, and __did __did not take an oath.

(Notary Seal) My Commission Expires

Notary Public State of Florida _____

Print Notary Name _____

Rev. 03/15 SEC0023A

This is how I want to contribute to the band:

PARENT NAME:_____

STUDENT(S) NAME:_____

PHONE (HOME)_____ ____ (CELL)_____ ____

(WORK) _____ ____ ("X" preferred phone)

EMAIL:_____

(ALL VOLUNTEERS MUST SIGN UP IN THE OFFICE BEFORE THEY CAN BE VOLUNTEERS IN THE SCHOOL. BE SURE TO USE THE EMAIL THAT YOU USE TO SIGN UP IN THE OFFICE SO WE CAN TRACK YOU VOLUNTEER HOURS)

We ask parents to help with at least **2 BAND EVENTS.** We always need chaperone help, but please help out wherever your talents and interests lie:

I am most interested in:

Chaperone_____ Concession _____ Uniforms_____ Sewing _____ Social / Events_____

Band Camp_____ Organizing Fund-raisers_____ Other Money Matters____ Notary _____

Building Things/Equipment_____

I have a truck and am willing to haul things for the band_____

PLEASE TELL US IF YOU HAVE A SPECIAL SKILL TO SHARE WITH THE BAND

_____

_____

_____

_____

*** Please note, when chaperoning or working a band event siblings that cannot supervise themselves may not attend.***

ST. LUCIE PUBLIC SCHOOLS
Fort Pierce, Florida
PARENTAL PERMISSION FORM

We, the undersigned parents of_____, hereinafter

referred to as the "student" do grant permission for the student to take a school

sponsored trip to: All Band Activities/Concert Performances 2020-2021.

The students will be accompanied by their teacher(s). Students will leave campus

As per band calendar **at** TBD **and return** As per band calendar

Date **Time** **Time**

My son/daughter understands that he/she must follow the rules and regulations of the St. Lucie Public School system as well as the Florida High School Athletic Association.

I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may be necessary for the student in the course of such activities or such travel.

Dated this_____day of_____, _____.

_____

_____
(telephone)

(If the permission is signed by persons other than the parents, the signer should identify his or her relationship with the student.)
Approved by the School Board: June 29, 2004

OPE0002A Rev. 09/14

EL2

Florida High School Athletic Association

Revised 05/14

Preparticipation Physical Evaluation (Page 1 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2. This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.

Part 1. Student Information (to be completed by student or parent)

Student's Name: _____ Sex: ____ Age: ____ Date of Birth: ____/____/____

School: _____ Grade in School: ____ Sport(s): _____

Home Address: _____ Home Phone: (____)_____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____

Relationship to Student: _____ Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Personal/Family Physician: _____ **City/State:** _____ **Office Phone: (____)**_____

Part 2. Medical History (to be completed by student or parent). Explain "yes" answers below. Circle questions you don't know answers to.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	___	___
2.	Do you have an ongoing chronic illness?	___	___
3.	Have you ever been hospitalized overnight?	___	___
4.	Have you ever had surgery?	___	___
5.	**Are you currently taking any prescription or non-**prescription (over-the-counter) medications or pills or using an inhaler?	___	___
6.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	___	___
7.	Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)?	___	___
8.	Have you ever had a rash or hives develop during or after exercise?	___	___
9.	Have you ever passed out during or after exercise?	___	___
10.	Have you ever been dizzy during or after exercise?	___	___
11.	Have you ever had chest pain during or after exercise?	___	___
12.	Do you get tired more quickly than your friends do during exercise?	___	___
13.	Have you ever had racing of your heart or skipped heartbeats?	___	___
14.	Have you had high blood pressure or high cholesterol?	___	___
15.	**Have you ever been told you have a heart murmur?**	___	___
16.	Has any family member or relative died of heart problems or sudden death before age 50?	___	___
17.	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___
18.	Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___
19.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)?	___	___
20.	Have you ever had a head injury or concussion?	___	___
21.	Have you ever been knocked out, become unconscious or lost your memory?	___	___
22.	Have you ever had a seizure?	___	___
23.	Do you have frequent or severe headaches?	___	___
24.	Have you ever had numbness or tingling in your arms, hands, legs or feet?	___	___
25.	**Have you ever had a stinger, burner or pinched nerve?**	___	___
26.	Have you ever become ill from exercising in the heat?	___	___
27.	Do you cough, wheeze or have trouble breathing during or after activity?	___	___
28.	Do you have asthma?	___	___
29.	Do you have seasonal allergies that require medical treatment?	___	___
30.	Do you use any special protective or corrective equipment or medical devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid)?	___	___
31.	Have you had any problems with your eyes or vision?	___	___
32.	Do you wear glasses, contacts or protective eyewear?	___	___
33.	Have you ever had a sprain, strain or swelling after injury?	___	___
34.	Have you broken or fractured any bones or dislocated any joints?	___	___
35.	**Have you had any other problems with pain or swelling in muscles,** tendons, bones or joints?	___	___

If yes, check appropriate blank and explain below:

___ Head	___ Elbow	___ Hip
___ Neck	___ Forearm	___ Thigh
___ Back	___ Wrist	___ Knee
___ Chest	___ Hand	___ Shin/Calf
___ Shoulder	___ Finger	___ Ankle
___ Upper Arm	___ Foot	

36.	Do you want to weigh more or less than you do now?	___	___
37.	Do you lose weight regularly to meet weight requirements for your sport?	___	___
38.	Do you feel stressed out?	___	___
39.	Have you ever been diagnosed with sickle cell anemia?	___	___
40.	Have you ever been diagnosed with having the sickle cell trait?	___	___

41. Record the dates of your most recent immunizations (shots) for:
Tetanus: _____ Measles: _____
Hepatitus B: _____ Chickenpox: _____

FEMALES ONLY (optional)

42. What was your first menstrual period? _____

43. When was your most recent menstrual period? _____

44. How much time do you usually have from the start of one period to the start of another? _____

45. How many periods have you had in the last year? _____

46. What was the longest time between periods in the last year? _____

Explain "Yes" answers here: _____

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 medical evaluation required by s.1006.20, Florida Statutes, 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 (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Student: _____ Date: ___/___/___ Signature of Parent/Guardian: _____ Date: ___/___/___

EL2

Revised 05/14

Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 2 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2. This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.

Part 3. Physical Examination (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).

Student's Name: _____ Date of Birth: ____/____/____

Height: _____ Weight: _____ % Body Fat (optional): _____ Pulse: _____ Blood Pressure: ___ / ___ (___/___ , ___/___)

Temperature: _____ Hearing: right: P _____ F _____ left: P _____ F _____

Visual Acuity: Right 20/_____ Left 20/_____ Corrected: Yes No Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
1. Appearance			
2. Eyes/Ears/Nose/Throat			
3. Lymph Nodes			
4. Heart			
5. Pulses			
6. Lungs			
7. Abdomen			
8. Genitalia (males only)			
9. Skin			
MUSCULOSKELETAL			
10. Neck			
11. Back			
12. Shoulder/Arm			
13. Elbow/Forearm			
14. Wrist/Hand			
15. Hip/Thigh			
16. Knee			
17. Leg/Ankle			
18. Foot			

* – station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation

____ Disability: _____ Diagnosis: _____

____ Precautions: _____

____ Not cleared for: _____ Reason: _____

____ Cleared after completing evaluation/rehabilitation for: _____

____ Referred to _____ For: _____

Recommendations: _____

Name of Physician/Physician Assistant/Nurse Practitioner (print): _____ Date: ____/____/____

Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____

EL2

Revised 05/14

Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 3 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2. This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation

____ Disability: _____ Diagnosis: _____

_____

____ Precautions: _____

_____

____ Not cleared for: _____ Reason: _____

____ Cleared after completing evaluation/rehabilitation for: _____

Recommendations: _____

Name of Physician (print): _____ Date: ___/___/_____

Address: _____

Signature of Physician: _____

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.

ACKNOWLEDGMENT OF RISK

COVID-19 and Voluntary Extracurricular Activities
Summer 2020 and 2020 – 2021 School year

I wish to allow my child to participate in a voluntary extracurricular activity conducted by the St. Lucie County School District ("School District"). I acknowledge and understand that the coronavirus known as Covid-19 has been declared a worldwide pandemic and is contagious and can be spread by person-to-person contact. As a result, Federal, state and local health agencies recommend social distancing and other measures to reduce the spread of Covid-19.

The School District will conduct extracurricular activities during the Summer of 2020 and continuing throughout the 2020 – 2021 school year. These activities will be conducted in accordance with health and safety protocols appropriate for the activity and for the conditions at the time. For the safety of all people involved, a child participating in the activity will be required to fully comply with all health and safety protocols and will be immediately removed from the activity if they do not fully comply. School based extracurricular activities are a privilege and not a right.

I acknowledge and understand that because of the Covid-19 pandemic that there is an increased risk to my child if they participate in school based extracurricular activities. I am aware of the health and safety protocols being implemented by the School District and I have weighed the risks to my child and I hereby consent to my child participating in the school based extracurricular activity identified below.

Extracurricular Activity:_____

Student Name:_____

_____
Parent/Guardian Signature

_____
Print Name of Parent/Guardian

_____
Date Signed