BEACHSIDE MONTESSORI VILLAGE

PHYSICAL EDUCATION & ATHLETICS DEPARTMENT

2230 LINCOLN STREET, HOLLYWOOD, FL 33020

August 2018

Dear Parents and Students,

Congratulations!! Your child has been selected to be on the Boys / Girls Soccer Team. This is a great honor and responsibility. Here is some information to ensure a successful season.
All athletes must:

- maintain a minimum GPA of 2.5 & must maintain a positive weekly progress report.
- have a signed Athletics Contract
- have a signed and **notarized** *Parental Permission/Insurance Statement.* (including copy of insurance card)
- **must have a medical evaluation and a stamped and signed medical clearance form.**
- have a signed *Release of Liability Authorization* allowing driving to practices/games.
- have a signed *Athletic Polices and Procedures Contract.*
- return uniforms at end of season, they will be loaned to all athletes at the beginning of the season
- attend practices and be picked up promptly at 5:00. Please move all the way down and do not block the curve.
- attend games at other schools. Depart BMV approx. @ 2:30 on Game Days.

If you are interested in volunteering, please choose one of the following:
Team Parent/Parent Driver/Athletic Booster Committee/Concessions contact the coach.

Looking forward to an amazing season!

Kim Rich
Athletic Director
kim.rich@browardschools.com

Beachside Montessori Village Athletics Policies and Procedures Contract

The following guidelines and policies will govern any athlete that is a member of Beachside Montessori Village Athletics program.

1. All athletes will conduct themselves in a manner that coincides with the guidelines listed in the Broward County Code of Student Conduct.

2. All athletes are expected to conduct themselves in a respectful and courteous manner at all times during practices, games, and especially in the classroom.

3. On game day, Athletes must attend at least a half-day of school to be eligible to participate.

4. Any athlete who is suspended from school during a particular season could face dismissal from the team. The coach, Athletic Director, and the administrator will review these situations on a case by case basis.

5. It is the responsibility of the student athlete to report to practice on time. Excessive tardiness to practice may result in loss of game time as determined by the coaching staff or dismissal from the team. Final administrator approval is required for athletes removal from a game or a team.

6. Completion of weekly progress reports is mandatory. Athletes are responsible for receiving and completing progress reports. If a student athlete receives a "D" or "F" on a weekly report, participation in that week's game(s) is at the discretion of the Athletic Director and/or school administration.

7. Progress reports must be completed and turned in to designated box specified by your coach, The Friday before the game week.

8. Parents are expected to pick up their child promptly after practices and games. Excessive tardiness in picking up players may result in the athlete's dismissal from the team.

These policies and the resulting disciplinary action will be strictly enforced. Please feel free to contact Coach Kim Rich with any concerns and/or kim.rich@browardschools.com

V. Roberts, Principal:_____

K. Rich, Athletic Director:_____

My signature below acknowledges that I understand the athletic policies and procedures and their consequences.

Student Athlete Name:_____

Date:_____

Student Athlete Signature:_____

Parent Name:_____

Date:_____

Parent Signature:_____

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754-323-8050

SCHOOL BOARD OF BROWARD COUNTY

RELEASE OF LIABILITY/AUTHORIZATION FOR ATHLETIC ACTIVITY

Student Name _____ Telephone _____

I authorize my child to utilize the type of transportation identified below for this field trip:
(X) School Bus (X) Charter Bus (X) Private Vehicle ( ) Walk

1. Maximum Capacity is one person per seat belt.
2. Field Trip destination: _____
3. Departure date/time: SEE BELOW

EMERGENCY CONTACT INFORMATION

In case of emergency, I may be reached at:

Contact Name _____ Location/Business Name _____ Telephone _____

In the event I cannot be reached, please contact:

Contact Name _____ Location/Business Name _____ Telephone _____

HEALTH/ACCIDENT INSURANCE

My child is covered by twenty-four (24) hour student accident insurance or family insurance:

Insurance Company _____ Policy Number _____

OR

I have attached a photocopy of my family insurance identification card.

OR

_____ I do not have insurance, however, I will pay any and all medical bills for emergency care of my child.

Teacher/Grade _____ **Signature of Parent/Guardian** _____

THIS FORM PERTAINS TO ALL OFF CAMPUS PRACTICES & GAMES FOR THE 2018- 2019 SPORTS SEASON.

STATE OF FLORIDA
School Entry Health Exam

To Parent/Guardian: Please complete and sign Part I — Child's Medical History.
State law for school entry requires a health examination by a legally qualified professional. Additional requirements may be determined by local school districts.

(Please Print)

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First, Middle)	

PART I — CHILD'S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1 through 8 below in the column on the left.
(Please explain any "Yes" answers in the space provided below.)

1. Yes ☐ No ☐ Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes ☐ No ☐ Any other specific illness or social/emotional or behavioral problems?
3. Yes ☐ No ☐ Any allergies (food, insects, medication, etc.)?
4. Yes ☐ No ☐ Any prescription medication (daily or occasionally)?
5. Yes ☐ No ☐ Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes ☐ No ☐ Any hospitalization, operation, or major illness (specify problem)?
7. Yes ☐ No ☐ Any significant injury or accident (specify problem)?
8. Yes ☐ No ☐ Would you like to discuss anything about your child's health with a school nurse?

To Parent/Guardian: Please explain any "Yes" answers from above.

_____

_____

_____

_____

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

☒ _____ _____
Signature of Parent/Guardian **Date**

Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

To Parent/Guardian: Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child's ability to learn in school. **(These services are recommended but not required.)**

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____ *(check one)* Optometrist ☐ Ophthalmologist ☐	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____ _____ Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____	Please describe any corrective action for any problems detected and any accommodations required.

Name of Child (Last, First, Middle)	Birth Date

PART II — MEDICAL EVALUATION

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date: _____ _____ _____
(Exam must be within one year of enrollment) Month Day Year

Screening Results:

Height: _____ Weight: _____ BMI%: _____ B/P: _____ Hct/Hgb: _____ Lead: _____ Urinalysis: _____

Vision - Without Glasses	Right 20/____	Left 20/____	Passed ☐ Failed ☐ Referred ☐	Hearing – Right	Passed ☐ Failed ☐ Referred ☐
Vision - With Glasses	Right 20/____	Left 20/____		Hearing – Left	Passed ☐ Failed ☐ Referred ☐

Gross dental (teeth and gums)	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Head/scalp/skin	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Eyes/Ears/Nose/Throat	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Chest/Lungs/Heart	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Abdomen	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Postural assessment	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____

TB risk assessment done ☐ ***(Please review Targeted Testing Guidelines listed below.)***

This child has the following problems that may impact the educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

☐ This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

(This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

☐ This child may participate fully in school activities including physical education.

☐ This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

Signature/Title of Health Care Provider	Date	Address (Please print or stamp)
☒	__/__/__	
Name (Please print or stamp)		

Tuberculosis Targeted Testing Guidelines for Health Care Providers

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if child is in one or more categories. The TB test is administered confidentially as part of the health examination. ***Do not record administration of any TB test or related information on this form.***

- Recent immigrant (< 5 years), frequent visitor to TB endemic areas
- Close contact to active TB case
- Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications

Active TB Disease Risk:

- Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.

Beachside Montessori Village

Interscholastic Sports

Parental Permission & Insurance Statement

I, _____ (Parent / Guardian), hereby grant permission for my son/daughter_____, (D.O.B ____ / ____ / _____), to participate interscholastic sports during the 2018-2019 school year.

My son /daughter has been examined by a physician and is physically qualified to participate in the sport(s) stated above. I authorize my child to accompany the school team, of which he or she is a member, on any of its local or out of town trips. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for my child as a result of game participation.

We have accident insurance with _____ (Name of Insurance Company) which will cover my son / daughter in the event of an interscholastic sports injury as required by School Board Policy #5304. I will assume responsibility for payment of doctor and hospital bills for treatment of an injury my son / daughter might suffer while participating in athletic activities. If any changes occur in this policy, it is the responsibility of the parent to notify the School Principal or Athletic Director. A photocopy of the front of the Insurer's policy card is attached.

(Signed) _____

Parent or Guardian

****NOTE****

PLEASE ATTACH A COPY OF VALID INSURANCE I.D. CARD