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Seminole Middle School

Color Guard Audition Information

We are so excited that you are interested in trying out for the SMS Color Guard Team! This is a very successful program and requires your time and dedication. We work hard, but we also have a lot of fun.

Practice: We Practice on Wednesdays from 4:20 — 6:30 and Fridays from 4:20-7:15. Attendance at practice is mandatory unless excused absent from school that day or prior arrangements have been made with the coaching staff.

Cost: There is a $30 fee for new members trying out. This will cover the cost of your flag pole. Payable by cash or money order only

Clothing: You MUST wear black leggings and black t-shirt or tank top and proper athletic undergarments. You may change before practice begins.

Audition Process: Students will work with our coaching staff and High School Team volunteers from September 4th— September 27thto learn basic movements and flag work. At the end of the four weeks you will perform as a group at the Seminole High School "Seminole Sound Specular" on Saturday September 28th. This performance will be your audition!

Requirements to Audition/Participate: As with all sports at our school you must have school insurance and a sports physical to participate. PCSB Student Insurance Website:

https://www.hsri.com/K12 Enrollment/Main/defauIt.asp

Click on Browse Rates, Pick the State and School District, and choose either the $5.00 or

$8.00 insurance

Cost for Season:

Season Dues: $ 490.00 This pays for Staff, show design, floor, props, flag material, transportation, etc. (will be broken up into 5 payments)

Uniform: $ 150.00 Uniform stays at SMS until after the last performance, and then it goes home for you to keep!

Rifle: $ 60.00 (not required, you may borrow one from the school)

We do a ton of fundraising, and you should be able to pay most of your dues through fundraising!

Any Questions contact Mrs. Evans at evansan@pcsb.org

2023 - 2024

Seminole Middle School Color Guard Student Information Sheet

Please print leqiblv

Student Information:

Student Name:

Address:

2021-2022 Grade: 

T-Shirt Size: Please Circle: s M L XL

Students e-mail:

Parent/Guardian Information:

Parent/Guardian Name(s):

Address:

Home Phone:

Cell Phone:

Parent e-mail:

Occupation/Employer:



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

Studcnt's Nanke: 

School: Grade in School: Sport(s):

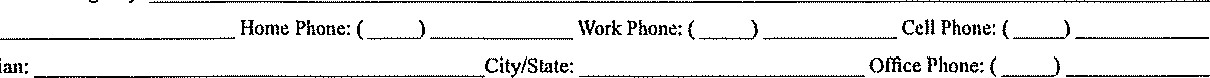
Home Address: 

Name of Parent/Guardian: E-mail:

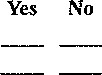


Person to Contact in Case of Emergency:

Relationship to Student:

Persona'/Family Physician:

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

Have you had a medical illness or injury since your last 26. Have you ever become ill from exercising in the heat?

check up or sports physical? 27. Do you cough, wheezc or have trouble brcathing during or after

1. Do you have un ongoing chronic illness? activity?
2. Have you ever been hospitalized ovemight?28. Do you have asthma?
3. Have you ever had surgery?29. Do you have seasonal allergies that require medical trcatmcnt?

|  |  |  |
| --- | --- | --- |
|  | prescription (over-the-countcr) medications or pills or | medical devices that aren't usualky used thr your sport or position |
|  | using an inhaler? | (for example, klee brace. special neck roll, foot orthotics, shunt\* |
| 6. | Have you ever taken any supplements or vitamins to | retainer on your teeth or hearing aid)? |

1. Are you currently taking any prescription or non-30. Do you use any special protective or corrective equipment or

help you gain or lose weight or improve your 31. Have you had any problems with your eyes or vision?

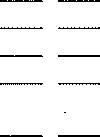
 performance? 32. Do you wear glasses, contacts or protective eyewear?

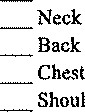
1. Do you have any allergies (for example, pollen, latex,  33. Have you ever had a sprain, strain or swelling aner injury?

medicine, tood or stinging insects)? 34. Have you broken or fractured any bones or dislocated any joints?

1. Have you ever had a rash or hives deveEop during or  35. Have you hod any other problems with pain or swelling in muscles,

|  |  |  |
| --- | --- | --- |
|  | after exercise? | tendons, bones or joints? |
| 9. | Have you ever passed out during or after excrcise? | Ifyes, check appmpriaie blank and explain below: |

10. Have you ever been dizzy during or after exercise?ElbowHip



Head

Have you ever had chest pain during or aftcr exercise? Forearm Thigh

1. Do you get tired more quickiy than your friends doWrist Knee during exercise?Hand Shin/Calf
2. Have you ever had racing of your heart or skippedShoulder Finger Ankle heartbeats?

 Upper Arm Foot

1. Have you had high blood pressure or high cholesterol? 36. Do you want to weigh more or tess than you do now?

Have you ever been told you have a heart murmur? 37. Do you lose weight regularly to meet weight requirements for your 

1. Has any family member or relative died of heartsport?

problens or sudden death before age 50? 38. Do you feel stressed out'?

|  |  |  |
| --- | --- | --- |
| 18. | Has a physician ever denied or restricted your | 41. Record the dates of your most recent immunizations (shoes) for: |
|  | participation in sports for any heart problems'? | Tetanus: Measles: |
| 19. | Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressurc sores)? | Hepatitus B: Chickenpox: |
| 20. | Have you ever had a head injury or concussion? | FEMALES ONLY (optional) |
| 21. | Have you ever been knocked out, become unconscious or | 42. When was your first Inenstrual period? |

1. Have you had a severe viral (for example,  39. Have you ever been diagnosed with sickle cell anemia?

myocarditis or mononucleosis) wilhin the last month? 40, Have you ever been diagnosed with having the sickle cell trait?

tost your memory?

43. When

1. Have you ever had a seizure? was your most recent menstruut period?

44. How much time the start of another?

1. Do you have frequent or severe headaches?do you usually have from the start of one period to
2. Have you ever had numbness or tingling in your arms, hands, legs or feet? How many periods have you had in the fast year? 45.

46. What was

1. Have you evcr had a stinger, burner or pinched nerve? the longest time between periods in the last year?



Explain "Yes" answers here:

We hereby state, lhe best of our knowledge. that our answers to the above questions are complete and correct. In addition the routine medical evaluation required by s. 1006.20, Florida Stntutes, 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 tcsts as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Student:

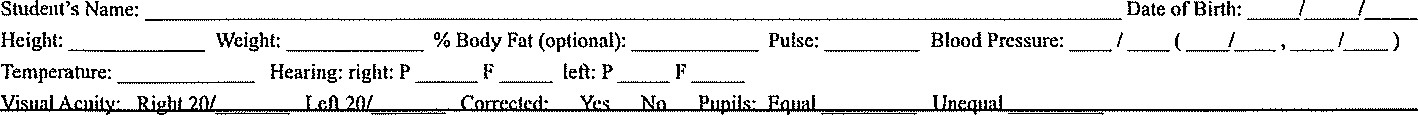


Date:

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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).



FINDINGS NORN•IAL ABNORMAL FINDINGS INITIALS\*

# MEDICAL

Appearance 

1. Eyes/Ears/Nose/Throat



1. Lymph Nodes



1. Heart



1. Pulses



1. Lungs



1. Abdomen
2. Genitalia (nules only) 

MUSCULOSKELETAL

10. Neck



n. Back



1. Shoulder/Arm



1. Elbow/Forearm



1. WrisUHand



1. Hiprrhigh 
2. K\_nee



1. Leg/Ankle



1. Foot





\*

station-based

examination

only

I hereby certify that each cxamination listcd abovc was perfonncd by myself or an individual under my direct supcrvision with thc following conclusion(s):

Cleared without limitation

Disability: Diagnosis:



Precautions:

Nol cleared tar: Reason:



Cleared after completing evaluation/rehabilitation for:





Referred toFor:

Recommendations:



Address:

Signature of PhysicianfPhysician Assistant}Nurse Practitioner:

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form lhc

Student's Name:

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)  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 ot• Physician (print): Address:

Signature of Physician:

Based on recommendations developed hy the American Academy ofFamily Physician', American Academy "'Pediatrics. Anterican Medical SocieD'for Sports Medicine, American Orthopaedic Societyfor Sports Medicine and American Osteopathic Academyfor SporÆs Medicine.

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