High School

ALL FORMS MUST BE SIGNED FOR AN ATHLETE TO BE ELIGIBILE!

SCHOOL USE ONLY

SANTA ROSA DISTRICT SCHOOLS
PRE-PARTICIPATION PHYSICAL EVALUATION FORM 2024-25

This completed form must be kept on file by the school and is valid 365 calendar days from the date of the physical evaluation.
This form is non-transferable; a change of schools during the validity period of this form will require student information and medical history to be re-submitted

Part 1. Student Information (to be completed by student and parent before a student is allowed to tryout, practice or compete).
Please print legibly in blue or black ink, or type.

Student Name: _____ Gender: _____ Age: _____ Birth Date: _____

High School: _____ **Grade for 2024-25 SY**: _____ Sport(s) _____

Home Address: _____ Home Phone: (_____) _____ - _____

Parent Guardian: _____ Work Phone: (_____) _____ - _____

Contact in Case of Emergency: _____ Contact Home Phone: (_____) _____ - _____

Contact Relationship to Student: _____ Contact Work Phone: (_____) _____ - _____

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

Part 2. Verification of Insurance Coverage

FHSAA REQUIRES ALL STUDENT ATHLETES TO PROVIDE PROOF OF HEALTH INSURANCE WITH A MINIMUM OF $25,000 COVERAGE. INSURANCE MAY EITHER BE PERSONAL OR PURCHASED THROUGH THE SCHOOL. MUST HAVE INSURANCE!

Please check one:

_____ **My/Our child/ward is currently covered under our family health insurance plan that has limits of no less than $25,000 coverage.**
Insurance Company Name: _____

Policy Number: _____

_____ **I/We have purchased voluntary student accident insurance through my/our child's/ward's school handled through Kid Guard and underwritten by Scholastic Insurance of Florida.**

I understand if during the course of the school year my/our child/ward loses coverage through a personal insurance plan, it is my responsibility to immediately notify the school athletic director. Voluntary student accident insurance offered through the school may be purchased at that time if no other personal coverage is available.

I understand that submission to testing for the presence of drugs and alcohol is a condition of participation in interscholastic athletics. I also understand that if I refuse to take the test, or if the test establishes a violation of the drug testing policy, I will face disciplinary action set forth by the drug testing policy. By signing and dating this form, I consent to take a preseason urinalysis if required. I agree to be random tested by draw throughout my sport's season(s). The preseason test, when required, is completed prior to the start of the particular sports season after tryouts are over. The random testing will be done weekly throughout the sports season. The draw for the random testing will be performed by an outside agency with the athletes being notified on the day they are to report for urinalysis. Random testing cost is covered by the School District. I also understand the provisions of reasonable suspicion. However, in the event a random drug screening produces a non-negative result all subsequent drug test costs will become the responsibility of the athlete. Furthermore, I also understand that the cost for the assessment and rehabilitation program, in the event of a violation of the drug testing policy is the responsibility of the athlete. I consent to allow the designated MRO (Medical Review Officer) to release follow-up drug testing results to school officials. By signing and dating this form, I attest I have read and understand the district random drug testing policy.

_____ _____ _____
(Student-Athlete's Signature) (Date) (Printed Name

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

I certify that the information provided herein is true and I consider him/her physically capable of participating in athletics. I hereby give my consent for the above-named student to (1) represent his/her school in athletic activities, except those exceptions cited by the examining physician provided that such athletic activities are approved by the State Association and (2) accompany any school team of which he/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 the student in the course of such athletic activities or such travel. I also agree not to hold the school or anyone acting on behalf of the Florida High School Activities Association responsible for any injury occurring to the above-named student in the course of such athletic activities or such travel. I also grant permission to the Santa Rosa County School System to release all athletic injury information that relates to the above-named student to the Emergency Health Care Facility involved in treatment.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices Act (Code of Student Conduct), and authorize designated Santa Rosa County School District Personnel, Santa Rosa County Health Department School Health personnel, and any other contracted healthcare agencies that may provide emergency care for my child and/or to exchange medical information, as necessary to support the continuity of care of my child.

Notarized Parent/Guardian Signature: DO NOT SIGN UNLESS YOU ARE IN THE PRESENCE OF A NOTARY!

_____ _____ _____
(Parent-Guardian Signature) (Printed Name) Date

State of Florida, County of Santa Rosa
Sworn and subscribed before me this _____ day of _____, 20___.
Person is: Personally known to me_____ Produced ID _____ Type ID _____ ID # _____

_____ _____
(Notary Signature) (Commission Expires) (Notary Seal)

IMPORTANT: While every effort will be made to uncover all potential health problems, a screening examination such as the one your child will receive cannot entirely eliminate the risks of athletic competition. **Health care costs exceeding school insurance coverage will be the responsibility of the parent/guardian.

ATTENTION PARENTS: THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY!!