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.

Date of Physical

SANTA ROSA DISTRICT SCHOOLS
PRE-PARTICIPATION PHYSICAL EVALUATION FORM 2014-15

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

This completed form must be kept on file by the school and is valid 365 calendar days from the date of the physical evaluation.

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: _____ Birthdate: _____

School: _____ Grade: 2014-15 _____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.

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 Fowinkle School Insurance Agency and underwritten by AIG Life Insurance Company.**

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. 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)

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 may child and/or to exchange medical information, as necessary to support the continuity of care of my child.

Notarized Parent/Guardian Signature:

_____ _____ _____

(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)

Part 3. **Medical History** (to be completed by parent) Explain "yes" answers below. Circle questions you do not know answers.

	YES	NO		YES	NO
1. Have you had a medical illness or injury since your last Check up or sports physical?			21. Do you have any allergies (i.e., to pollen, food, medicine or stinging insects)?		
2. Do you have an ongoing chronic illness?			22. Have you ever had a head injury or concussion?		
3, Have you ever been hospitalized overnight?			23. Have you ever had a rash or hives develop after exercise?		
4. Have you ever had surgery?			24. Do you have seasonal allergies that require medical treatment?		
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?			25. Do you have any current skin problems (for ex: itching, rashes, acne, warts fungus or blisters)?		
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?			26. Have you ever had a sever viral infection (for ex.: myocarditis, or mononucleosis)?		
7. Do you want to weigh more or less than you do now?			27. Have you had high blood pressure or high cholesterol?		
8. Do you feel stressed out?			28. Do you get tired more quickly than your friends during exercise?		
9. Do you lose weight regularly to meet weight requirements?			29. Have you ever been dizzy during or after exercise?		
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for ex.: knee brace, special neck roll, foot orthotics retainer on your teeth, hearing aid)?			30. Have you ever become ill from exercising in the heat?		
			31. Have you ever passed out during/after exercise?		
			32. Have you ever had a sprain, strain or swelling after an injury?		
11. Have you had any problems with your eyes or vision?			33. Have you ever been told you have a heart murmur?		
12. Do you wear glasses, contacts or protective eyewear?			34. Have you ever had chest pain during/after exercise?		
13. Have you ever had racing of your heart or skipped heartbeats?			35. Has a physician ever denied or restricted your participation in sports for any heart problems?		
14. Have you broken or fractured any bones or dislocated any joints?			36. Has any family member/relative died of heart problems or sudden death before age 50?		
15. Have you had any other problems with pain/swelling in muscles, tendons, bones or joints? If yes, check all that apply and explain below:			37. Do you cough, wheeze or have trouble breathing during/after an activity?		
_____Head _____Elbow _____Hip ____Shoulder _____Neck _____Knee _____Forearm ___Thigh _____Back _____Wrist _____Chest ___Hand _____Finger _____Ankle _____Shin/Calf ___Upper Arm _____Foot			38. Record the dates of your most recent immunizations for: Tetanus:_____Measles_____ HepatitisB:_____Chickenpox:_____		
			39. Have you ever been diagnosed with measles?		
16. Have you ever had numbness or tingling in your arms, hands, leg or feet?			40. Have you ever had a stinger, burner or pinched nerve?		
			41. Have you ever been diagnosed with mumps?		
17. Do you have frequent or sever headaches?			FEMALES ONLY (optional)		
18. Have you ever had a seizure?			42. When was your first menstrual period? _____		
19. Do you have asthma?			43. When was your most recent menstrual period? _____		
20. Have you ever been knocked out, become unconscious or lost your memory?			44. How many periods have you had in the last year? _____ 45. What was the longest time between periods in the last year? _____ 46. How much time do you usually have from the start of one period to the start of another? _____		

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 11.8, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests such as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Student: _____ **Signature of Parent:** _____

Part 4. Physical Examination (to be completed by physician).

Student's Name: _____**DOB:** _____**Height** _____**Wt.**_____ **% Body Fat (optional)**_____

Pulse: _____ **Blood Pressure**_____/_____ **Visual Acuity: Right 20/**____ **Left 20/**____ **Corrected: Yes No Pupils: Equal** ____**Unequal**_____

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

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 conclusions:

RECOMMENDATIONS:

1. _____ **Cleared without limitation. Student may participate in any competitive athletic event.**
2. _____ **Not cleared for** _____ **Reason:** _____
3. _____ **Cleared after completing evaluation/rehabilitation for** _____
4. _____ **This student should not participate in any competitive athletic event.**

Name of Physician/Nurse Practitioner/Licensed Physician Assistant: _____ **Address:** _____

Physician's Signature: _____ **Phone:** _____ **Date:** _____