SCHOOL DISTRICT OF ESCAMBIA COUNTY

75 NORTH PACE BLVD
PENSACOLA, FL 32505
PHONE (850) 432-6121
http://www.escambia.k12.fl.us
MALCOLM THOMAS, SUPERINTENDENT

July 8, 2016

Dear Parents/Guardians of High School Athletes:

The School District provides for an "Excess Blanket Athletic Insurance Policy" that will provide accidental medical coverage for students injured while participating in District or Florida High School Activities Association (FHSAA) sanctioned extra-curricular athletic activities. The District and FHSAA (for high school students) requires that all students trying out for or competing in school district sponsored athletics remain covered by a medical insurance policy at all times. The District pays the entire premium for this "Blanket Policy" that provides uniform coverage for all athletes without risk of cancellation due to loss or ineligibility for continued coverage. This policy can provide valuable insurance coverage for parents that either do not have insurance, or those parents that have existing coverage under either a **"private"** (UHC, Blue Cross, Humana, Aetna, etc...) or **"public"** (Tricare, Medicaid, Champus, etc...) medical insurance plan. For parents who have existing insurance, this "Excess Plan" will pay for many out-of-pocket expenditures (co-pays, deductibles, coinsurance, etc...) based on the attached "Schedule of Benefits".

This policy is secondary coverage for students who are already covered by a **"private"** family policy, but shall be primary coverage for the students who have no other insurance coverage, or are covered by a **"public"** family policy. Athletes are covered by this Excess Blanket Policy while participating in extra-curricular athletics under school sponsorship and supervision; and while being transported by approved district transportation. A description of the plan (schedule of values) including policy exclusions and limitations can be found attached to this letter or from your coach. ***The School District shall not be responsible for costs of treating injuries or assume liability for any other costs associated with an injury while participating in extra-curricular athletic activities including, but not limited to, out-of-pocket medical expenses.***

The policy is issued through Mutual of Omaha Insurance Company and claims will be administered by Health Special Risk, Inc. If you have any questions concerning the policy, claims, or coverage you may contact them at 1-866-409-5734, or visit them on-line at www.healthspecialrisk.com.

For parents with existing medical insurance coverage with a private or public insurance carrier, you will still need to provide your coach with a copy of your existing medical insurance card in the event that your child needs medical treatment and to assist with the filing of claims (primary or secondary coverage).

In addition, parents will be required to complete and sign FHSAA and District required forms prior to try-outs or any participation in athletic activities: "**Pre-participation Physical Evaluation", "Athletic Consent and Release from Liability Certificate", "Consent and Release from Liability Certificate for Concussion and Heat-Related Illness",** and the "**Consent and Release from Liability Certificate for Sudden Cardiac Arrest and Concussion".**

We appreciate the opportunity to serve your student and student athletes in Escambia County and we are pleased to provide you with this valuable "blanket policy" for the 2016-17 school year. If you have any questions concerning the insurance program, please contact Kevin Windham, Director of Risk Management, at (850)469-6162 you may also contact your school's head coach, athletic director or principal.

Please let us know if you have any questions or if we can assist you in any way.

Sincerely,

Malcolm Thomas

Malcolm Thomas
Superintendent

July 2016

Dear Parents:

The School District of Escambia County has chosen Mutual of Omaha Insurance Company to provide insurance coverage for all Middle School and High School Interscholastic Athletics for the 2016/2017 school year. ***Health Special Risk, Inc. (HSR)*** will be the policy and claims administrator for Mutual of Omaha, the same administrator for the past 6 years.

This insurance plan provides coverage on a secondary/excess basis and pays after any other coverage you may have. If you have no other coverage, this plan pays as primary coverage.

Please read through the benefits attached to this letter. This plan is not meant to pay 100% of the bills. Note the benefit limits within the policy. The maximum benefit is $25,000 for each injury.

Also attached to this letter is a claim form which includes instructions for filing a claim. Only one claim form per injury is needed. Coaches and Athletic Directors will be responsible for completing the school's portion of the claim form in the event of an injury. Once the school's portion of the claim form is completed, parents are then responsible for having the remainder of the claim form completed, attaching the doctor's bill, Explanations of Benefits (EOB's) from your primary insurance company and submitting it to the address on the claim form.

If you have claim questions, please call **1-866-409-5734 Toll-Free from 9:00 AM to 7:00 PM.** Thank you for your continued support.

Parents are urged to keep this letter and attachments on file in the event of an injury during the year.

SERVICE PROVIDED BY:

Health Special Risk, Inc.

HSR Plaza II

4100 Medical Parkway, Carrollton, Texas 75007

(972) 512-5600

cassandratalton@hsri.com

www.healthspecialrisk.com

SCHOOL DISTRICT OF ESCAMBIA COUNTY
MIDDLE SCHOOL AND HIGH SCHOOL ATHLETICS COVERAGE
Accident Only Insurance Policy – Schedule of Benefits – SR2014FLLG-P-100330
Claims Administered by *Health Special Risk, Inc. (HSR)*

Persons Covered:

The insurance shall cover on a blanket basis all middle school and high school athletes in the play or practice of interscholastic athletics while under the supervision of a regularly employed coach or trainer or qualified adult school authority of the policyholder. This coverage includes being transported in a school furnished vehicle as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the above mentioned interscholastic athletic competitions. Spring training, off-season workouts and play-off games as defined and sanctioned by the state interscholastic governing body and coaching staff supervised off season, off premises High School Football conditioning camps are included under this coverage.

The Policy provides for loss due to a covered Injury up to the Maximum Benefit of $25,000 for each Injury. Provided that the treatment begins within **60 days** from the date of the Injury, benefits will be paid for Covered Medical Expenses incurred within **52 weeks** from the date of Injury up to the maximum benefit per service as scheduled below. Any service or supply not specifically listed is not covered.

Inpatient

- Room & Board: Semi-private room rate/$150 per day
- Hospital Miscellaneous: $600 per day
- Registered Nurse's Services: 75% of Usual & Customary Charges
- Physician's Visits: $40 first day/$25 each subsequent day *(Benefits are limited to one visit per day and do not apply when related to surgery)*

Outpatient

- Day Surgery Miscellaneous: $1,000 maximum *(Usual & Customary Charges are based on the Outpatient Surgical Facility Charge Index.)*
- Physician's Visits: $40 first day/$25 each subsequent day *(Benefits are limited to one visit per day and benefits for Physicians visits do not apply when related to surgery or physiotherapy)*
- Physiotherapy: $30 first day/$20 each subsequent day/5 days maximum *(Benefits are limited to one visit per day)*
- Emergency Room: $150 maximum *(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)*
- X-Rays: $200 maximum
- Cat Scan/MRI: $300 maximum
- Laboratory: $50 maximum
- Injections: No Benefits
- Prescription Drugs: $75 maximum
- Orthopedic Braces & Appliances: $75 maximum
- Durable Medical Equipment (*post surgical only*): $150.00 maximum

Inpatient and/or Outpatient

- Surgeon's Fees: $1,000 maximum *(Specified Surgery based on data provided by Ingenix, Inc.) (No more than one procedure through the s0jwame incision will be paid)*
- Anesthetist/Assistant Surgeon: 20% of Surgery Allowance
- Ambulance: $300 maximum

- Consultant: $200 maximum
- Dental: $200 per tooth *(Benefits are paid on Injury to Sound, Natural Teeth Only)*
- Replacement of Eye Glasses, Contact Lenses Or Hearing Aids: $200 maximum *(As a result of a Covered Injury)*

- *Usual and Customary Charges are based on data provided by Ingenix, Inc. using the 75th percentile.*
- *Benefits will be provided as required by the State of Florida for Extension of Benefits after Termination if the Covered Person is Totally Disabled,*
- *This is a brief illustration of coverage offered through the K12 Student Athletic and Activities Accident Insurance.*
- *The Master Policy issued is the contract and will govern and control the payment of benefits.*
- *The policy contains an Excess Provision. No benefits are payable for expense incurred that is paid or payable by other valid and collectible insurance.*
- *The Policy is a non-renewable one year term policy.*

POLICY EXCLUSIONS AND LIMITATIONS

No coverage is provided for:

1. Injuries resulting from air travel except while as a passenger for transportation only; operating, sitting or riding in or upon, alighting to or from, or working on or around any motorcycle or recreational vehicle including but not limited to: two or three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV); jet ski; ski cycle; snowmobile or off-road motorized vehicle not requiring licensing as a motor vehicle.
2. The cost of dental treatment, except for accidental Injury to Sound, Natural Teeth.
3. Injuries received while under the influence of any controlled substance, unless administered on the advice of a physician.
4. Injuries received as a result of being intoxicated (as determined and defined by the laws in the jurisdiction which the loss or cause of loss was incurred; for the purposes of this exception, the laws governing the operation of motor vehicles while intoxicated will apply to any activity occurring at the time of the accident).
5. Expenses for which benefits are paid or payable by Worker's Compensation or employer's liability law.
6. Injury where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
7. Injuries caused by an act of war, declared or undeclared
8. Re-injury or complications of a condition for which medical advice or treatment was recommended by a physician or received from a physician within a 6 month period preceding the effective date of individual insurance.
9. Injuries received while skiing, scuba diving, surfing, roller skating, riding in a rodeo.
10. Injuries received while skydiving, parachuting, hang gliding, glider flying, flight in an ultra light aircraft, parasailing, sail planing, bungee jumping, bob-sledding, or ballooning.
11. Suicide or attempt thereat, while sane or insane; injuries received while fighting or brawling (except in self-defense).
12. Injuries received while traveling except as described in the policy.

Injuries mean accidental bodily injuries: (a) received while insured under this policy; and (b) resulting independently of sickness and all other causes.

EXCESS INSURANCE PROVISION

Even if you have other insurance, the Plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other insurance. Benefits will be paid on the unpaid balances after your other insurance has paid. Benefits are payable for any expense which is not recoverable from any other insurance policy or service contract.

HOW TO FILE A CLAIM

NOTE: Medical Treatment must be received from a qualified licensed Physician within 60 days from the date of accident.

1. **All claims need to be first filed with any primary insurance inforce such as the injured student's parent's group medical insurance.**
2. **Obtain a claim form quickly from our website www.healthspecialrisk.com; from your school office or call *Health Special Risk, Inc. (HSR)* toll free at 1-866-409-5734.**
3. **Answer all questions in detail and include signatures to avoid claim from being returned for incomplete information.**
4. **Attach all ITEMIZED BILLS (NOT "Balance Due" statements) AND copies of your primary insurance company's "Explanation of Benefits" (EOB) detailing the payments made by them to the completed form and mail to *HSR* as soon as possible.**
5. **Any bills not filed with the claim form should be sent to *HSR* identified with the student's name, school district, and date of accident.**
   Bills that cannot be attached to the initial form must be submitted within 60 days of the date of service. Bills submitted after one year will not be considered for payment except on the absence of legal capacity.

ACCIDENTAL DEATH AND DISMEMBERMENT

If such Injury shall independently of all other causes and within 180 days from the date of accident solely result in any one of the following specific losses, the Covered Person or beneficiary may request the Company to pay the applicable amount below in lieu of payment under the "Medical Expense Benefits" provision.

- Loss of Life $10,000.00
- Loss of Both Hands, Both Feet, or Sight of Both Eyes $10,000.00
- Loss of One Hand and One Foot..... $10,000.00
- Loss of Either One Hand or One Foot and Sight of One Eye $10,000.00
- Loss of Speech and Hearing..... $10,000.00
- Loss of One Hand or One Foot or Sight of One Eye $5,000.00
- Loss of Speech or Hearing $5,000.00
- Loss of Entire Thumb and Index Finger of Either Hand $500.00

Underwritten by:

Mutual of Omaha Insurance Company, Omaha, Nebraska

Claims Administered by:

***Health Special Risk, Inc.*, Carrollton, Texas**

SR2014FLLG-P-100330

School District:

The School District of Escambia County

School Name:

Student ID Number:

HSR
Health Special Risk, Inc.

P.O. Box 117558
Carrollton, Texas 75011-7558
Phone: (972) 512-5600 Fax: (972) 512-5818
Toll Free (866) 409-5734
E-mail : K12claims@hsri.com

STUDENT CLAIM FORM

1. **Please fully complete this form**
2. **Attach itemized bills**
3. **Mail, E-mail or Fax to *HSR***

PART I – POLICYHOLDER'S REPORT

1. Claimant's Name (injured/ill person)	2. Social Security Number	3. Gender ☐ M ☐ F	4. Date of Birth	5. E-Mail
6. Address of Injured Person				7. Phone Number (include area code)
8. Parent/Legal Guardian Name, Address, City, State & Zip				9. Phone Number (include area code)

10. Date of Accident/Illness	11. Time of Accident ☐ a.m. ☐ p.m.	12. Place where Accident Occurred	13. Date of First Treatment

Dental Claims	14. Indicate which Teeth were Involved in the Accident	15. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

16. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) Did Injury Result in Death? ☐Yes ☐No

17. Describe How Accident Occurred or the Nature of the Illness – Give all possible details

18. Which Best Describes the Activity:		
☐ Play or practice of interscholastic sports	☐ During lunch hour	☐ Athletic period
☐ Not school related	☐ In school bus	☐ On school property during school hours
☐ P.E. class	☐ School sponsored field trip	☐ School sponsored activity during school hours
	☐ Traveling to/from school	☐ ROTC activity

19. Name of Person Supervising the Activity	20. If engaged in an Interscholastic Sport at the time of the injury, what was the sport?

Signature of Parent/Legal Guardian: X	Date:	Signature of School Official: X	Date:

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐ Yes ☐ No

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

If applicable, claimant's primary employer name, address, and phone number _____

If applicable, mother's primary employer name, address, and phone number _____

If applicable, father's primary employer name, address, and phone number _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.

Signature of Parent/Legal Guardian: X	Date:	Signature of Witness: X	Date:

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim. (If not signed submit proof of payment)

SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____

By entering your name above in Part II and Part III, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

FRAUD STATEMENTS

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska and Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.
Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas, Louisiana, Maryland, West Virginia &Rhode Island: Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.
Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida: WARNING :Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
Georgia: Any natural person who knowingly or willfully
1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:
    a) In any written statement;
    b) In the filing of a claim; or
    c) In the receiving of money for an application for a policy of insurance for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;
2) Receives money for the purpose of purchasing insurance and converts such money to such persons own benefit;
3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or
4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement for the purpose of fraudulently obtaining money or benefit from an insurer commits the crime of insurance fraud.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.
Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects the person to criminal and civil penalties.
Minnesota; A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.
New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
New Mexico and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon: Warning: Any person who knowingly, and with intent to defraud any insurance company or other persons files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be subject to prosecution for insurance fraud.
Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding "**OTHER INSURANCE STATEMENT**", marking either yes or no, and signing the line for authorization, so that ***HSR*** and the doctors/hospital may communicate concerning your claim.
   Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to the address shown below.
4. DO NOT assume that anyone else will mail this claim form to ***HSR*** for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to ***HSR*** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment and amount) incurred (including the CPT/procedure code).
4. If this information is not on the bill when you send this in we will have to contact the doctor/hospital which will delay the review of your claim. "Balance Due" or "Balance Forward" statements do not contain sufficient information to complete your claim.

EXCESS INSURANCE

1. This policy provides coverage on a secondary/excess basis. If you have any other primary insurance coverage you need to send the bills to your primary insurance first.
2. ***HSR*** will consider benefits after your other, primary insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why.
4. ***HSR*** will not be able to consider your claim without this information.

If you have any questions, please contact Customer Service at (866) 409-5734. They are available from 8:00 a.m. thru 6:00 p.m. central time, Monday – Friday. You may also forward any documents by fax to (972) 512-5818.

Health Special Risk, Inc.
P.O. Box 117558
Carrollton, TX 75011-7558

Florida High School Athletic Association

Revised 03/16

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. When 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: ____/ ____/ ____

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: _____

Florida High School Athletic Association

Revised 03/16

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.**

Student's Name: _____

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.

EL3

Florida High School Athletic Association

Revised 04/16

Consent and Release from Liability Certificate (Page 1 of 4)

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

School: _____ **School District (if applicable):** _____

Part 1. Student Acknowledgement and Release (to be signed by student at the bottom)

I have read the (condensed) FHSAA Eligibility Rules printed on Page 4 of this "Consent and Release Certificate" and know of no reason why I am not eligible to represent my school in interscholastic athletic competition. If accepted as a representative, I agree to follow the rules of my school and FHSAA and to abide by their decisions. I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury, including the potential for a concussion, and even death, is possible in such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved. Should I be 18 years of age or older, or should I be emancipated from my parent(s)/guardian(s), I hereby release and hold harmless my school, the schools against which it competes, the school district, the contest officials and FHSAA of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against FHSAA because of any accident or mishap involving my athletic participation. I hereby authorize the use or disclosure of my individually identifiable health information should treatment for illness or injury become necessary. I hereby grant to FHSAA the right to review all records relevant to my athletic eligibility including, but not limited to, my records relating to enrollment and attendance, academic standing, age, discipline, finances, residence and physical fitness. I hereby grant the released parties the right to photograph and/or videotape me and further to use my name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein. I understand that the authorizations and rights granted herein are voluntary and that I may revoke any or all of them at any time by submitting said revocation in writing to my school. By doing so, however, I understand that I will no longer be eligible for participation in interscholastic athletics.

Part 2. Parental/Guardian Consent, Acknowledgement and Release (to be completed and signed by a parent(s)/guardian(s) at the bottom; where divorced or separated, parent/guardian with legal custody must sign.)

A. I hereby give consent for my child/ward to participate in any FHSAA recognized or sanctioned sport **EXCEPT** for the following sport(s):

_____

List sport(s) exceptions here

B. I understand that participation may necessitate an early dismissal from classes.

C. I know of, and acknowledge that my child/ward knows of, the risks involved in interscholastic athletic participation, understand that serious injury, and even death, is possible in such participation and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. With full understanding of the risks involved, I release and hold harmless my child's/ward's school, the schools against which it competes, the school district, the contest officials and FHSAA of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against the FHSAA because of any accident or mishap involving the athletic participation of my child/ward. I authorize emergency medical treatment for my child/ward should the need arise for such treatment while my child/ward is under the supervision of the school. I further hereby authorize the use or disclosure of my child's/ward's individually identifiable health information should treatment for illness or injury become necessary. I consent to the disclosure to the FHSAA, upon its request, of all records relevant to my child/ward's athletic eligibility including, but not limited to, records relating to enrollment and attendance, academic standing, age, discipline, finances, residence and physical fitness. I grant the released parties the right to photograph and/or videotape my child/ward and further to use said child's/ward's name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein.

D. I am aware of the potential danger of concussions and/or head and neck injuries in interscholastic athletics. I also have knowledge about the risk of continuing to participate once such an injury is sustained without proper medical clearance.

READ THIS FORM COMPLETELY AND CAREFULLY. YOU ARE AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA USES REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH, TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND MY CHILD'S/WARD'S SCHOOL, THE SCHOOLS AGAINST WHICH IT COMPETES, THE SCHOOL DISTRICT, THE CONTEST OFFICIALS AND FHSAA HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

E. I agree that in the event we/I pursue litigation seeking injunctive relief or other legal action impacting my child (individually) or my child's team participation in FHSAA state series contests, such action shall be filed in the Alachua County, Florida, Circuit Court.

F. I understand that the authorizations and rights granted herein are voluntary and that I may revoke any or all of them at any time by submitting said revocation in writing to my school. By doing so, however, I understand that my child/ward will no longer be eligible for participation in interscholastic athletics.

G. Please check the appropriate box(es):

____ My child/ward is covered under our family health insurance plan, which has limits of not less than $25,000.

Company: _____ **Policy Number:** _____

____ My child/ward is covered by his/her school's activities medical base insurance plan.

____ I have purchased supplemental football insurance through my child's/ward's school.

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE (Only one parent/guardian signature is required)

Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date
		____/____/____
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date
		____/____/____

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE (student must sign)

Name of Student (printed)	Signature of Student	Date
		____/____/____

Florida High School Athletic Association

Consent and Release from Liability Certificate for Concussions (Page 2 of 4)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the most recent signature.

School: _____ **School District (if applicable):** _____

Concussion Information

Concussion is a brain injury. Concussions, as well as all other head injuries, are serious. They can be caused by a bump, a twist of the head, sudden deceleration or acceleration, a blow or jolt to the head, or by a blow to another part of the body with force transmitted to the head. You can't see a concussion, and more than 90% of all concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. All concussions are potentially serious and, if not managed properly, may result in complications including brain damage and, in rare cases, even death. Even a "ding" or a bump on the head can be serious. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, your child should be immediately removed from play, evaluated by a medical professional and cleared by a medical doctor.

Signs and Symptoms of a Concussion:

Concussion symptoms may appear immediately after the injury or can take several days to appear. Studies have shown that it takes on average 10-14 days or longer for symptoms to resolve and, in rare cases or if the athlete has sustained multiple concussions, the symptoms can be prolonged. Signs and symptoms of concussion can include: (not all-inclusive)

- Vacant stare or seeing stars
- Lack of awareness of surroundings
- Emotions out of proportion to circumstances (inappropriate crying or anger)
- Headache or persistent headache, nausea, vomiting
- Altered vision
- Sensitivity to light or noise
- Delayed verbal and motor responses
- Disorientation, slurred or incoherent speech
- Dizziness, including light-headedness, vertigo(spinning) or loss of equilibrium (being off balance or swimming sensation)
- Decreased coordination, reaction time
- Confusion and inability to focus attention
- Memory loss
- Sudden change in academic performance or drop in grades
- Irritability, depression, anxiety, sleep disturbances, easy fatigability
- In rare cases, loss of consciousness

DANGERS if your child continues to play with a concussion or returns too soon:

Athletes with signs and symptoms of concussion should be removed from activity (play or practice) immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to sustaining another concussion. Athletes who sustain a second concussion before the symptoms of the first concussion have resolved and the brain has had a chance to heal are at risk for prolonged concussion symptoms, permanent disability and even death (called "Second Impact Syndrome" where the brain swells uncontrollably). There is also evidence that multiple concussions can lead to long-term symptoms, including early dementia.

Steps to take if you suspect your child has suffered a concussion:

Any athlete suspected of suffering a concussion should be removed from the activity immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without written medical clearance from an appropriate health-care professional (AHCP). In Florida, an appropriate health-care professional (AHCP) is defined as either a licensed physician (MD, as per Chapter 458, Florida Statutes), a licensed osteopathic physician (DO, as per Chapter 459, Florida Statutes). Close observation of the athlete should continue for several hours. You should also seek medical care and inform your child's coach if you think that your child may have a concussion. Remember, it's better to miss one game than to have your life changed forever. When in doubt, sit them out.

Return to play or practice:

Following physician evaluation, the ***return to activity process*** requires the athlete to be completely symptom free, after which time they would complete a step-wise protocol under the supervision of a licensed athletic trainer, coach or medical professional and then, receive written medical clearance of an AHCP.

For current and up-to-date information on concussions, visit http://www.cdc.gov/concussioninyouthsports/ or http://www.seeingstarsfoundation.org

Statement of Student Athlete Responsibility

Parents and students should be aware of preliminary evidence that suggests repeat concussions, and even hits that do not cause a symptomatic concussion, may lead to abnormal brain changes which can only be seen on autopsy (known as Chronic Traumatic Encephalopathy (CTE)). There have been case reports suggesting the development of Parkinson's-like symptoms, Amyotropic Lateral Sclerosis (ALS), severe traumatic brain injury, depression, and long term memory issues that may be related to concussion history. Further research on this topic is needed before any conclusions can be drawn.

I acknowledge the annual requirement for my child/ward to view "Concussion in Sports-What You Need to Know" at www.nfhslearn.com. I accept responsibility for reporting all injuries and illnesses to my parents, team doctor, athletic trainer, or coaches associated with my sport including any signs and symptoms of CONCUSSION. I have read and understand the above information on concussion. I will inform the supervising coach, athletic trainer or team physician immediately if I experience any of these symptoms or witness a teammate with these symptoms. Furthermore, I have been advised of the dangers of participation for myself and that of my child/ward.

_____	_____	_____/_____/_____
Name of Student-Athlete (printed)	Signature of Student-Athlete	Date
_____	_____	_____/_____/_____
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date

Revised 04/16

Florida High School Athletic Association

Consent and Release from Liability Certificate for Sudden Cardiac Arrest and Heat-Related Illness (Page 3 of 4)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the most recent signature.

School: _____ **School District (if applicable):** _____

Sudden Cardiac Arrest Information

Sudden cardiac arrest is a leading cause of sports-related death. This policy provides procedures for educational requirements of all paid coaches and recommends added training. Sudden cardiac arrest is a condition in which the heart suddenly and unexpectedly stops beating. If this happens, blood stops flowing to the brain and other vital organs. SCA can cause death if it's not treated within minutes.

Symptoms of sudden cardiac arrest include, but not limited to: sudden collapse, no pulse, no breathing.

Warning signs associated with sudden cardiac arrest include: fainting during exercise or activity, shortness of breath, racing heart rate, dizziness, chest pains, extreme fatigue.

It is strongly recommended all coaches, whether paid or volunteer, are regularly trained in CPR and the use of an AED. Training is encouraged through agencies that provide hands-on training and offer certificates that include an expiration date.

Automatic external defibrillators (AEDs) are required at all FHSAA State Series games, tournaments and meets. The FHSAA also strongly recommends that they be available at all preseason and regular season events as well along with coaches/individuals trained in CPR.

What to do if your student-athlete collapses:

1. **Call 911**
2. **Send for an AED**
3. **Begin compressions**

FHSAA Heat-Related Illnesses Information

People suffer heat-related illness when their bodies cannot properly cool themselves by sweating. Sweating is the body's natural air conditioning, but when a person's body temperature rises rapidly, sweating just isn't enough. Heat-related illnesses can be serious and life threatening. Very high body temperatures may damage the brain or other vital organs, and can cause disability and even death. Heat-related illnesses and deaths are preventable.

Heat Stroke is the most serious heat-related illness. It happens when the body's temperature rises quickly and the body cannot cool down. Heat Stroke can cause permanent disability and death.

Heat Exhaustion is a milder type of heat-related illness. It usually develops after a number of days in high temperature weather and not drinking enough fluids.

Heat Cramps usually affect people who sweat a lot during demanding activity. Sweating reduces the body's salt and moisture and can cause painful cramps, usually in the abdomen, arms, or legs. Heat cramps may also be a symptom of heat exhaustion.

Who's at Risk?
Those at highest risk include the elderly, the very young, people with mental illness and people with chronic diseases. However, even young and healthy individuals can succumb to heat if they participate in demanding physical activities during hot weather. Other conditions that can increase your risk for heat-related illness include obesity, fever, dehydration, poor circulation, sunburn, and prescription drug or alcohol use.

By signing this agreement, the undersigned acknowledges that the information on Sudden Cardiac Arrest and Heat-Related Illness have been read and understood. I acknowledge optional educational opportunities in cardiac arrest at www.nfhslearn.org. Please go to www.fhsaa.org/departments/health for further instructions to view the courses. I have been advised of the dangers of participation for myself and that of my child/ward.

_____	_____	_____/_____/_____
Name of Student-Athlete (printed)	Signature of Student-Athlete	Date
_____	_____	_____/_____/_____
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date

Florida High School Athletic Association

Revised 04/16

Consent and Release from Liability Certificate (Page 4 of 4)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the most recent signature.

Attention Student and Parent(s)/Guardian(s)

Your school is a member of the Florida High School Athletic Association (FHSAA) and follows established rules. To be eligible to represent your school in interscholastic athletics, in an FHSAA recognized sport (i.e. bowling, competitive cheerleading, girls flag football, lacrosse, boys volleyball, water polo and girls weightlifting or sanctioned sport (i.e. baseball, basketball, cross country, tackle football, golf, soccer, fast-pitch softball, swimming & diving, tennis, track & field, girls volleyball, boys weightlifting and wrestling), the student:

1. **This form is non-transferable**; a separate form must be completed for each different school at which a student participates.
2. Must be regularly enrolled and in regular attendance at your school. **If the student is a home education student or attends a charter school or Florida Virtual School - Full time Program or a special/alternative school or certain small non-member private schools, the student must declare in writing his/her intention to participate in athletics to the school at which the student is permitted to participate.** Home education students and students attending small non-member private schools must be approved through the use of a separate form prior to any participation. (FHSAA Bylaw 9.2, Policy 16 and Administrative Procedure 1.8)
3. Must attend school within 10 days of the beginning of **each semester** to be eligible during **that semester**. (FHSAA Bylaw 9.2)
4. Must maintain at least a cumulative 2.0 grade point average on a 4.0 unweighted scale prior to the semester in which the student wishes to participate. This GPA must include all courses taken since the student entered high school. A sixth, seventh or eighth grade student must have earned at least a 2.0 grade point average on 4.0 unweighted scale the previous semester. (FHSAA Bylaw 9.4)
5. Must not have graduated from any high school or its equivalent. (FHSAA Bylaw 9.4)
6. Must not have **enrolled in the ninth grade for the first time** more than four school years ago. If the student is a sixth, seventh or eighth grade student, the student must not participate if repeating that grade. (FHSAA Bylaw 9.5)
7. Must have signed permission to participate from the student's parent(s)/legal guardian(s) on a form (EL3) provided the school. (Bylaw 9.8)
8. Must be less than 19 years 9 months old to participate in high school; 16 years 9 months old to participate in junior high school; and 15 years 9 months old to participate in middle school, otherwise the student becomes ineligible to participate at that level. Students entering 9th grade in 2014-15 and thereafter must not turn 19 before September 1st, otherwise the student becomes ineligible to participate. (FHSAA Bylaw 9.6)
9. Must undergo a pre-participation physical evaluation and be certified as being physically fit for participation in interscholastic athletics (form EL2).
10. Must be an amateur. This means the student must not accept money, gift or donation for participating in a sport, or use a name other than his/her own when participating. (FHSAA Bylaw 9.9)
11. Must not participate in an all-star contest in a sport prior to completing his/her high school eligibility in that sport. (FHSAA Policy 26)
12. Must display good sportsmanship and follow the rules of competition **before, during and after** every contest in which the student participates. If not, the student may be suspended from participation for a period of time. (FHSAA Bylaw 7.1)
13. Must not provide false information to his/her school or to the FHSAA to gain eligibility. (FHSAA Bylaw 9.1)
14. Youth exchange, other international and immigrant students must be approved by the FHSAA office prior to any participation. Exceptions may apply. See your school's principal/athletic director. (FHSAA Policy 17)
15. Must refrain from hazing/bullying while a member of an athletic team or while participating in any athletic activities sponsored by or affiliated with a member school.

If the student is declared or ruled ineligible due to one or more of the FHSAA rules and regulations, the student has the right to request that the school file an appeal on behalf of the student. See the principal or athletic director for information regarding this process.

By signing this agreement, the undersigned acknowledges that the information on the Consent and Release from Liability Certificate in regards to the FHSAA's established rules and eligibility have been read and understood.

Name of Student-Athlete (printed)	Signature of Student-Athlete	Date
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Department of Curriculum and Instruction
75 N. Pace Blvd.
Pensacola, FL 32505

ANNUAL CONSENT TO STUDENT DRUG SCREENING

SCHOOL YEAR 2016 - 2017

I understand that submission to testing for the presence of drugs is a conditions of parking on campus and/or participation in interscholastic athletics and/or extra/co-curricular activities. I further understand if I refuse to take the test, or if the test establishes a violation of the random drug test policy, I will forfeit my privilege of parking on campus and be removed from participation in athletics and/or extra/co-curricular activities until satisfactorily complying with the Random Drug Testing Policy.

By signing and dating this form, I consent to random drug screening and the sanctions thereof throughout the school year. The selection for the random screenings will be performed on a weekly basis with the selected students being notified on the day they are to report for urinalysis.

By signing and dating this form, I understand that the cost of the initial random screening will be paid for by the school district. Furthermore, I understand that the cost of all follow-up drug testing will be the responsibility of the student if the follow-up test results in a positive outcome. If the results are determined to be negative, the district will be responsible for reimbursement. I also understand that the cost for the assessment and rehabilitation program and any additional testing in the event of a violation of the random drug testing policy is also the responsibility of the student.

I hereby consent to the administration of the drug screening and to the conditions listed in this consent. By signing and dating this form, I attest that I have read and understand the attached Random Drug Testing Policy.

Student's Name:_____ Student ID:_____

Date :_____ Signature:_____

Parent/Guardian's Name:_____

Date :_____ Signature:_____

Notary Signature:_____ Date:_____

Commission Expires:_____

(Notary Seal)

If your child is selected for random drug screening, an attempt will be made to notify you either by phone or letter of both selection for screening and the subsequent result. The best number to reach you is _____. An alternate number is _____.