

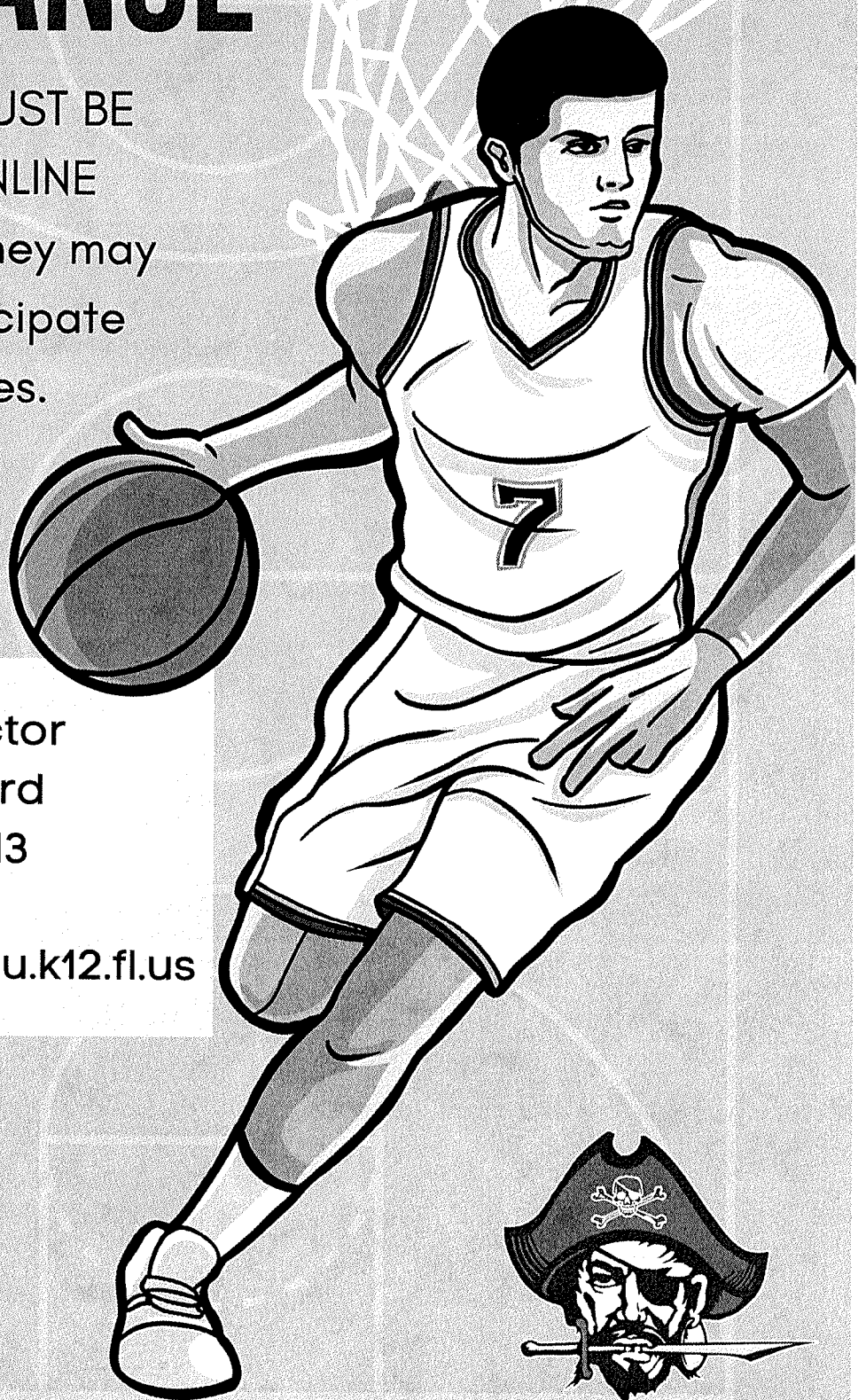
# ATHLETIC CLEARANCE

2024-2025

All students **MUST BE**  
**CLEARED ONLINE**  
online before they may  
tryout or participate  
in practices.

Athletic Director  
Mike Woodard  
904-261-5713  
ext. 2615

[woodardmi@nassau.k12.fl.us](mailto:woodardmi@nassau.k12.fl.us)



**FENANDINA BEACH HIGH SCHOOL ATHLETICS**  
**HEAD COACHES' DIRECTORY**  
**2024-2025**

<b>Athletic Director</b>	<b>Mike Woodard</b>	woodardmi@nassau.k12.fl.us
<b>Athletic Trainer</b>	<b>Lindsay Herd</b>	lindsay.herd@jax.ufl.edu
<b>FALL</b>		
<b>Bowling</b>	<b>Jonathon Alexander</b>	alexanderjo@nassau.k12.fl.us
<b>Cheerleading</b>	<b>Jensen Armstrong</b>	armstrongje@nassau.k12.fl.us
<b>Cross-Country - Boys</b>	<b>Bill Rule*</b>	rule_bill@yahoo.com
<b>- Girls</b>	<b>Dave Reinhart*</b>	davereinhardt99@gmail.com
<b>Football</b>	<b>Blake Willis</b>	williswi@nassau.k12.fl.us
<b>Golf - Boys</b>	<b>Christina Steffen</b>	steffench@nassau.k12.fl.us
<b>- Girls</b>	<b>Christina Steffen</b>	steffench@nassau.k12.fl.us
<b>Swimming - Boys</b>	<b>Bill Stewart</b>	stewartwi@nassau.k12.fl.us
<b>- Girls</b>	<b>Bill Stewart</b>	stewartwi@nassau.k12.fl.us
<b>Volleyball</b>	<b>Kayla Duggan</b>	dugganka@nassau.k12.fl.us
<b>WINTER</b>		
<b>Basketball - Boys</b>	<b>Matt Bringman</b>	coachbringman34@gmail.com
<b>- Girls</b>	<b>Donte Ford</b>	forddo@nassau.k12.fl.us
<b>Soccer - Boys</b>	<b>Pete Kovalick*</b>	kovalickp@bellsouth.net
<b>- Girls</b>	<b>Amy Strozinsky</b>	strozinskyam@nassau.k12.fl.us
<b>Wrestling - Boys</b>	<b>Eric Kubatzke*</b>	erickubatzke@gmail.com
<b>- Girls</b>	<b>Erin Mahoney*</b>	erinmahoney79@gmail.com
<b>Weightlifting - Girls</b>	<b>Jonathon Alexander</b>	alexanderjo@nassau.k12.fl.us
<b>SPRING</b>		
<b>Baseball</b>	<b>Jon Shave</b>	shavejo@nassau.k12.fl.us
<b>Beach Volleyball</b>	<b>Lee Calhoun*</b>	lee.calhoun1489@gmail.com
<b>Football Flag</b>	<b>Donte Ford</b>	forddo@nassau.k12.fl.us
<b>Lacrosse</b>	<b>Tom Fricano*</b>	tcfricano@bellsouth.net
<b>Softball</b>	<b>Cris Holland*</b>	cptcrisholland@aol.com
<b>Tennis - Boys</b>	<b>Carrie Vitori*</b>	carrievitori@gmail.com
<b>- Girls</b>	<b>Susan DeMille*</b>	susiedemille@aol.com
<b>Track - Boys</b>	<b>Bill Rule*</b>	rule_bill@yahoo.com
<b>- Girls</b>	<b>Sarah Twardy</b>	twardysa@nassau.k12.fl.us
<b>Weightlifting - Boys</b>	<b>Blake Willis</b>	williswi@nassau.k12.fl.us

## ATHLETIC CLEARANCE

*Quick steps for parents/students using the online athletic clearance process.*

1. Visit <https://athleticclearance.fhsaahome.org/>
2. Select Florida
3. First Time Users:

- Create an Account. PARENTS/GUARDIANS will register with a valid email username and password.

4. Return Users:

- Enter login information and click "Sign In"

5. Sign In using your email address that you registered with

6. Select "Start Clearance Here" to start the process.

7. Choose:

- School Year in which the student plans to participate.
- School at which the student attends and will compete at

- Sport/s (We recommend that if the student will be participating in multiple sports, that those sports are added all at once)

8. Complete all required fields for Student Information, Parent/Guardian Information, Medical History, Signature Forms and upload a File if applicable. (If you have gone through the Athletic Clearance process before, you will select the Student and Parent/Guardian from the dropdown menu on those pages and the information will autofill)

9. Once you reach the Confirmation Message you have completed the online registration process.

10. The student is not Cleared yet! This data will be electronically filed with your school's athletic department for review. When the student has been cleared for participation, an email notification will be sent.

Questions? Use the yellow Help option on the bottom right of the screen and submit a ticket.

## **Online Athletic Clearance FAQ**

### **What is my Username?**

Your username is the email address that you registered with.

### **How do I register for multiple Sports?**

If you know you are going to play multiple sports when registering, it is best to add all sports on the first step where you also select the school year and school. If you are registering for additional sports after completing your initial clearance for the year, you will have to complete the process again. The good news is that if you select the student & parent/guardian info from the dropdown on those respective pages, the information will autofill.

### **Physicals**

The physical form your school uses can be downloaded on Medical History page.

### **Your Files**

This area is meant to store your files so they can be accessed later in the year or perhaps years following.

### **Why haven't I been cleared?**

Your school will review the information you have submitted before clearing you for participation. Once they review your clearance they will change the status. You will receive an email when you have been cleared for participation

### **My sport is not listed!**

Please contact your school's athletic department and ask for your sport to be activated.

### **I was "Denied" clearance, now what?**

You should have received an email with the reason for denial. Please update your clearance accordingly then contact your school's athletic department and ask them to review your information again.



**PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)**  
*This medical history form should be retained by the healthcare provider and/or parent.*  
*This form is valid for 365 calendar days from the date signed below.*

**EL2**

Revised 4/24

**MEDICAL HISTORY FORM**

**Student Information** (to be completed by student and parent) *print legibly*

Student's Full Name: \_\_\_\_\_ Biological Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_  
Family Healthcare Provider: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

List past and current medical conditions:

Have you ever had surgery? If yes, please list all surgical procedures and dates:

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

**Patient Health Questionnaire version 4 (PHQ-4)**

*Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)*

	Not at all	Several days	Over half of the days	Nearly everyday
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

GENERAL QUESTIONS		Yes	No	HEART HEALTH QUESTIONS ABOUT YOU (continued)		Yes	No
Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.							
1	Do you have any concerns that you would like to discuss with your provider?			8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
2	Has a provider ever denied or restricted your participation in sports for any reason?			9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
3	Do you have any ongoing medical issues or recent illnesses?			10	Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No
4	Have you ever passed out or nearly passed out during or after exercise?			11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash)		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			12	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
7	Has a doctor ever told you that you have any heart problems?						

**This form is not considered valid unless all sections are complete.**



**PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)**  
*This medical history form should be retained by the healthcare provider and/or parent.*  
*This form is valid for 365 calendar days from the date signed below.*

**EL2**

Revised 4/24

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ School: \_\_\_\_\_

BONE AND JOINT QUESTIONS		Yes	No	MEDICAL QUESTIONS (continued)		Yes	No
14	Have you ever had a stress fracture?			26	Do you worry about your weight?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			27	Are you trying to or has anyone recommended that you gain or lose weight?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?			28	Are you on a special diet or do you avoid certain types of foods or food groups?		
MEDICAL QUESTIONS		Yes	No	29	Have you ever had an eating disorder?		
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?			Explain "Yes" answers here: _____ _____ _____ _____ _____ _____ _____ _____			
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?						
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?						
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?						
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?						
22	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?						
23	Have you ever become ill while exercising in the heat?						
24	Do you or does someone in your family have sickle cell trait or disease?						
25	Have you ever had or do you have any problems with your eyes or vision?						

**This form is not considered valid unless all sections are complete.**

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. Florida Statute 1006.20 requires a student candidate for an interscholastic athletic team to successfully complete a preparticipation physical evaluation as the first step of injury prevention. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

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 physical evaluation required by Florida Statute 1006.20, 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 (ECG), echocardiogram (ECHO), and/or cardio stress test. The FHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: \_\_\_\_\_ (printed) Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ (printed) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ (printed) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



**PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)**  
*This medical history form should be retained by the healthcare provider and/or parent.*  
*This form is valid for 365 calendar days from the date signed below.*

**EL2**

Revised 4/24

**PHYSICAL EXAMINATION FORM**

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ School: \_\_\_\_\_

**HEALTHCARE PROFESSIONAL REMINDERS:**

Consider additional questions on more sensitive issues.

• Do you feel stressed out or under a lot of pressure?	• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Do you drink alcohol or use any other drugs?	• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	• Have you experienced performance changes, felt fatigued, and/or experienced times of low energy during the past year?

- ☐ Verify completion of FHSAA EL2 Medical History (pages 1 and 2), review these medical history responses as part of your assessment.  
Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

EXAMINATION			
Height:	Weight:		
BP: ____ / ____ ( ____ / ____ )	Pulse: _____	Vision: R 20/____ L 20/____ Corrected: Yes No	
MEDICAL - healthcare professional shall initial each assessment		NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"><li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li></ul>			
Eyes, Ears, Nose, and Throat <ul style="list-style-type: none"><li>Pupils equal</li><li>Hearing</li></ul>			
Lymph Nodes			
Heart <ul style="list-style-type: none"><li>Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)</li></ul>			
Lungs			
Abdomen			
Skin <ul style="list-style-type: none"><li>Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis</li></ul>			
Neurological			
MUSCULOSKELETAL - healthcare professional shall initial each assessment		NORMAL	ABNORMAL FINDINGS
Neck			
Back			
Shoulder and Arm			
Elbow and Forearm			
Wrist, Hand, and Fingers			
Hip and Thigh			
Knee			
Leg and Ankle			
Foot and Toes			
Functional <ul style="list-style-type: none"><li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li></ul>			

**This form is not considered valid unless all sections are complete.**

\*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. The FHSAA Sports Medicine Advisory Committee strongly recommends to a student-athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.

Name of Healthcare Professional (print or type): \_\_\_\_\_ Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Signature of Healthcare Professional: \_\_\_\_\_ Credentials: \_\_\_\_\_ License #: \_\_\_\_\_

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# PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/24

## MEDICAL ELIGIBILITY FORM

**Student Information** (to be completed by student and parent) *print legibly*

Student's Full Name: \_\_\_\_\_ Biological Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_  
Family Healthcare Provider: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

The preparticipation physical evaluation must be administered by a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with the practitioner's regulatory board. (§1006.20(2)(c), F.S.)

- ☐ Medically eligible for all sports without restriction  
☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

☐ Medically eligible for only certain sports as listed below:

☐ Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

I hereby certify that I, or a clinician under my direct supervision, have examined the above-named student-athlete using the FHSAA EL2 Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): \_\_\_\_\_ Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Signature of Healthcare Professional: \_\_\_\_\_ Credentials: \_\_\_\_\_ License #: \_\_\_\_\_

### SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

- ☐ Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp *(if required by school)*

Medications: *(use additional sheet, if necessary)*

List: \_\_\_\_\_

Relevant medical history to be reviewed by athletic trainer/team physician: *(explain below, use additional sheet, if necessary)*

- ☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait ☐ Other

Explain: \_\_\_\_\_

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct. 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 (ECG), echocardiogram (ECHO), and/or cardio stress test.

**This form is not considered valid unless all sections are complete.**





## PREPARTICIPATION PHYSICAL EVALUATION (Supplement)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

**EL2**

Revised 4/24

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

### MEDICAL ELIGIBILITY FORM - Referred Provider Form

**Student Information** (to be completed by student and parent) *print legibly*

Student's Full Name: \_\_\_\_\_ Biological Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_  
Family Healthcare Provider: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

Referred for: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

- ☐ Medically eligible for all sports without restriction as of the date signed below  
☐ Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

☐ Medically eligible for only certain sports as listed below:

☐ Not medically eligible for any sports

Further Recommendations: *(use additional sheet, if necessary)*

Name of Healthcare Professional (print or type): \_\_\_\_\_ Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Signature of Healthcare Professional: \_\_\_\_\_ Credentials: \_\_\_\_\_ License #: \_\_\_\_\_

Provider Stamp *(if required by school)*

- ALL Student-Athletes MUST complete annually the following FHSAA required NFHS Learn courses, per FHSAA policy, before participation: (all courses are **FREE**)

Upon completion, certificates are to be included in uploaded documents to athletic clearance.

1. <https://nfhslearn.com/courses/concussion-for-students>
2. <https://nfhslearn.com/courses/heat-illness-prevention-2>
3. <https://nfhslearn.com/courses/sudden-cardiac-arrest>

# ***The Nassau County School District***

## **PROOF OF ACCIDENT INSURANCE**

Required for Athletic, Cheerleading, and Extracurricular Activity Participants

The Florida Statutes and the Nassau County School Board Administrative Rule 5.71 require that students participating in Interscholastic Athletics, Cheerleading, and Extracurricular Activities **MUST** have accident insurance, and proof of the insurance is to be kept on file at the school.

This is to confirm that my child, \_\_\_\_\_, who is a  
(Print Name of Student)  
student at \_\_\_\_\_ is covered under the  
(Name of School)  
following accident insurance policy:

Name of Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

**I understand that my child will not be permitted to participate in Interscholastic Athletics, Cheerleading, and/or Extracurricular Activities without accident insurance, and I agree to maintain accident insurance coverage for my child during his/her participation.**

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_\_ by  
(Date)

\_\_\_\_\_, who is personally known to me or who has  
(Name of Person Acknowledged)

produced \_\_\_\_\_ as identification and who did (did not)  
(Type of Identification)

take an oath.

\_\_\_\_\_  
(Title or Rank)

\_\_\_\_\_  
(Signature of Notary taking Acknowledgment)

\_\_\_\_\_  
(Serial Number, if any)

\_\_\_\_\_  
(Name of Notary, typed, printed or stamped)

*Our mission is to develop each student as an inspired life-long learner and problem-solver  
with the strength of character to serve as a productive member of society.*

# Nassau County School District

## Medical Authorization Form

\_\_\_\_ (Student's Name) has my permission to participate in extra-curricular activities sponsored or authorized by \_\_\_\_\_ School and/or the School Board of Nassau County.

In my absence or in the absence of an authorized parent or guardian of the Participant, I hereby authorize The School Board of Nassau County, Florida, its agents, servants, employees or designees to administer first aid and to obtain and consent to on behalf of the Participant and Participant's parents or guardians, any emergency first aid or medical care by any physician, hospital, or attendant which is deemed necessary or expedient by said physician, hospital or attendant as a result of involvement in the Activity. I agree to abide and be bound by such decisions and consents as if made by me and do assume full financial responsibility for and agree to pay all expenses of such care. I understand that it is my responsibility to secure adequate insurance for such first aid and medical care. The name of our health insurance company is \_\_\_\_\_ Policy Number \_\_\_\_\_.

I further authorize any physician, hospital or medical attendant to receive full and complete medical reports or information deemed necessary by them with respect to the treatment of my child. Execution of this document shall operate as an authorization for such person(s) to receive any medical information which they require.

The medical authorization contained within this form shall be valid and usable by The School Board of Nassau County during such periods of time as my child is enrolled in a school within said District and this authorization shall remain valid unless revoked by me in writing.

Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_\_ by  
(Date)

\_\_\_\_\_, who is personally known to me or who has  
(Name of Person Acknowledged)

produced \_\_\_\_\_ as identification and who did (did not) take an oath.  
(Type of Identification)

\_\_\_\_\_  
(Title or Rank)

\_\_\_\_\_  
(Signature of Notary taking Acknowledgment)

\_\_\_\_\_  
(Serial Number, if any)

\_\_\_\_\_  
(Name of Notary, typed, printed or stamped)

### **MIDDLE AND HIGH SCHOOL STUDENTS:**

I hereby certify that I have read, understand and agree to abide by all of the rules of conduct and regulations of The School Board of Nassau County and if appropriate, the Florida High School Activities and Athletic Association. Any violation of these rules and regulations will subject me to disciplinary action.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# The Nassau County School District

1201 Atlantic Avenue  
Fernandina Beach, Florida 32034

"Empowering others through a commitment to e

Dr. Kathy K. Burns, Ed.D.  
Superintendent of Schools

(904) 491-9900  
Fax (904) 277-9042  
info@nassau.k12.fl.us

## NASSAU COUNTY SCHOOL BOARD STUDENT DRUG TESTING CONSENT FORM

I understand that submission to testing for the presence of drugs and alcohol is a condition of participation in extracurricular activities and for the operation of a motor vehicle on school property. I further 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 Nassau County School Board policy.

By signing and dating this form, I consent to any random or reasonable suspicion drug testing that might be required during the 2024-2025 school-year. The random testing will be done throughout the school year. The selection for the random testing will be performed by the testing agency with the selected students being notified on the day they are to report for drug testing. I also understand the provisions of reasonable suspicion testing.

By signing and dating this form I understand that the costs for random and reasonable suspicion testing will be paid for by the school district. 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 student.

I hereby consent to the administration of a drug test, if selected, and to the conditions listed in this consent. By signing and dating this form I attest that I have read and understand Nassau County School Board Rule 2.48, which outlines the district drug testing policy printed in the Code of Student Conduct.

Student's Name: \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Signature of Notary: \_\_\_\_\_ Date: \_\_\_\_\_

Commission Expires: \_\_\_\_\_

***Our mission is to develop each student as an inspired life-long learner and problem-solver with the strength of character to serve as a productive member of society.***

The Nassau County School District does not discriminate on the basis of race, color, national origin, gender, age, disability or marital status in its educational programs, services or activities, or in its hiring or employment practices.