# ATHLETIC CLEARANCE

All students must have the following completed to be cleared to participate in Gateway Athletics:

- ❑ Register athlete on www.athleticclearance.com
  - **ALL FILES MUST BE UPLOADED TO ATHLETIC CLEARANCE**
  - ***UPLOAD- Confirmation page that is signed by parent and student***
  - MAKE SURE YOU SELECT ALL SPORTS THAT YOU ARE GOING TO PARTICAPATE IN EVEN IF YOU ARE INTERESTED, OTHERWISE YOU WILL HAVE TO UPLOAD SEPERATE CONFIRMATION PAGE FOR ANY SPORT ADDED AT A LATER DATE.

- ❑ Updated sports physical uploaded onto Athletic Clearance Profile
  - Physicals must be on FHSAA physical form
  - ***UPLOAD ONLY PG 4 WITH PHYSICIAN, PARENT, & STUDENT SIGNATURES COMPLETED* (Upload Supplement page if further doctor evaluation is needed)**
  - PAPER COPIES WILL NOT BE ACCEPTED

- ❑ ECG uploaded onto Athletic Clearance
  - Only need 1 ECG for 4 years of High School
  - Incoming freshman ECG must be completed after April 1, 2025
  - If you participated at Gateway last year, we would have your ECG and it will not be required to upload if you use the same login information.

- ❑ Impact Concussion Baseline Test completed online each school year (Begins 6/1/2025)
  - Website: www.impacttestonline.com/testing
  - Launch Code: NRZ2BM6JIE

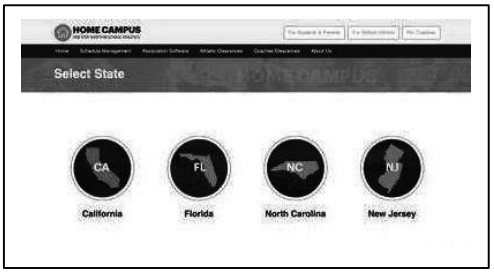
- ❑ Watch NFHS Safety Videos & upload completion certificate on Athletic Clearance
  - Register on www.NFHSLearn.com
  - **Must complete Concussion for Students, Heat Illness Prevention, Sudden Cardiac Arrest, and Sportsmanship** (Begins 6/1/2025)
  - ***UPLOAD CERTIFICATE OF COMPLETION FOR EACH COURSE ON ATHLETIC CLEARANCE***

- ❑ $35 Athletic Participation Fee paid on Athletic Clearance
  - Electronic payment on Donations page of Athletic Clearance

***COACHES WILL NOT BE PERMITTED TO ALLOW STUDENT ATHLETES TO PARTICIPATE IN PRACTICES OR ANY ACTIVITIES UNTIL ATHLETIC CLEARANCE STATES CLEARED OR PRACTICE ONLY***

# ONLINE ATHLETIC CLEARANCE

**1** **VISIT ATHLETICCLEARANCE.COM**
**CHOOSE FLORIDA**
**LOG INTO ACCOUNT**




**New Users**
Create an account. Please register with a valid PARENT/GUARDIAN email address as the username and generate a password.

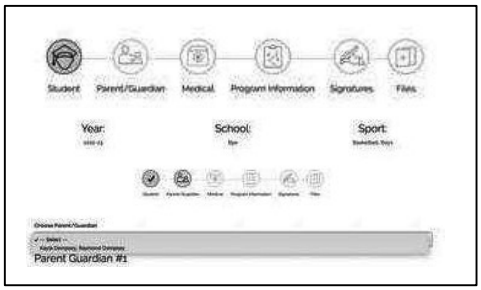
**Return Users**
Log into existing accountused in previous School Year.


**2** **SELECT START CLEARANCE HERE**


**Select**
School Year in which student plans to participate.
School where student will participate Sport(s).

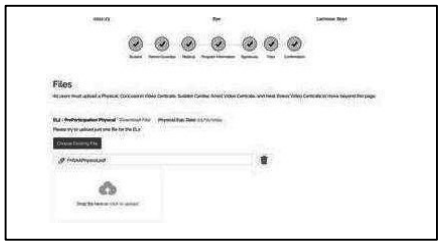
**Participating in multiple sports?** Use Add New Sport button.


**3** **COMPLETE ALL REQUIRED FIELDS**
Student Information, Parent/Guardian Information, Medical History, Signature Forms, and upload any File(s).




**Student Info & Parent Guardian Info**
If you have previously used Athletic Clearance select student or parent/guardian from the dropdown menu. Most fields will autofill with previous information. **Be sure to update the fields that are not autofilled.**

**Files**
Drag & drop or browse from your computer to add a file. Select Choose Existing File to search for a previously uploaded file.




**CLICK**
**SUBMIT COMPLETED APPLICATION**

**4** **CONFIRMATION MESSAGE**


Your clearance is ready for review by your school once you have reached the CONFIRMATION MESSAGE page.

**THE STUDENT IS NOT CLEARED YET!**
**THE SCHOOL MUST REVIEW AND CLEAR THE STUDENT. AN EMAIL NOTIFICATION WILL BE SENT ONCE THE SCHOOL HAS REVIEWED AND CLEARED THE STUDENT FOR PARTICIPATION.**

**CONTACT HOME CAMPUS**
SUPPORT@HOMECAMPUS.COM
HOMECAMPUS.COM

**QUESTIONS?**
**USE THE HELP ICON AT THE BOTTOM RIGHT SCREEN FOR ASSISTANCE!**

Help

# Non-Traditional Student Quick Reference

Please register all non-traditional students via Home Campus using the EL13 - New or Returning Non-traditional Student Registration form.

| Type of Student | May Participate at | Required forms: |
|---|---|---|
| Type 1<br>Home Education<br>(Includes FLVS – Flex)<br>*Bylaw 9.2.2.1* | Zoned Public School<br>Public School of Choice<br>Charter or Lab School<br>Private School (if allowed) | EL2/EL3 – Physical/Consent<br>EL7 – Home Education Participation<br>EL7V – Home Education Verification<br>EL14 – Student Controlled Open Enrollment (if applicable)<br>GA4 – Recruiting Policy Affidavit<br>Official Grade Record |
| Type 2<br>Charter<br>*Bylaw 9.2.2.2* | Zoned Public School<br>Public School of Choice<br>Charter or Lab School<br>Private School (if allowed) | EL2/EL3 – Physical/Consent<br>EL14 – Student Controlled Open Enrollment (if applicable)<br>GA4 – Recruiting Policy Affidavit<br>Official Transcript |
| Type 3<br>Special School<br>(Includes FLVS – District Franchise)<br>*Bylaw 9.2.2.3* | Public School (within the district the student resides)<br>Private School (if allowed) | EL2/EL3 – Physical/Consent<br>GA4 – Recruiting Policy Affidavit<br>Official Transcript |
| Type 4<br>Non-Member Private<br>*Bylaw 9.2.2.4* | Any Public School<br>Charter or Lab School<br>Private School (if allowed) | EL2/EL3 – Physical/Consent<br>EL12 – Non-member Private School Student<br>GA4 – Recruiting Policy Affidavit<br>Official Transcript |
| Type 5<br>FLVS – Full Time<br>*Bylaw 9.2.2.5* | Zoned Public School<br>Public School of Choice<br>Charter or Lab School<br>Private School (if allowed) | EL2/EL3 – Physical/Consent<br>EL14 – Student Controlled Open Enrollment (if applicable)<br>GA4 – Recruiting Policy Affidavit<br>Official Transcript |
| Type 6<br>Traditional Public School<br>*Bylaw 9.2.2.6* | Public School (within the district the student resides)<br>Private School (if allowed) | EL2/EL3 – Physical/Consent<br>GA4 – Recruiting Policy Affidavit<br>Official Transcript |
| Type 7<br>Public Transfer<br>*Bylaw 9.2.2.7* | If the student participated in a sport at their previous school, the student could continue to participate in that sport at that school for the remainder of the school year | EL2/EL3 – Physical/Consent<br>GA4 – Recruiting Policy Affidavit<br>Official Transcript |

**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 of exam.*

**EL2**

Revised 2/25

## 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 Questionaire 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** Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer. | Yes | No |
|---|---|---|---|
| 1 | Do you have any concerns that you would like to discuss with your provider? | | |
| 2 | Has a provider ever denied or restricted your participation in sports for any reason? | | |
| 3 | Do you have any ongoing medical issues or recent illnesses? | | |
| | **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 4 | Have you ever passed out or nearly passed out during or after exercise? | | |
| 5 | Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 6 | Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | | |
| 7 | Has a doctor ever told you that you have any heart problems? | | |

| | **HEART HEALTH QUESTIONS ABOUT YOU** *(continued)* | **Yes** | **No** |
|---|---|---|---|
| 8 | Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)? | | |
| 9 | Do you get light-headed or feel shorter of breath than your friends during exercise? | | |
| 10 | Have you ever had a seizure? | | |
| | **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 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) | | |
| 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 catecholaminerigc polymorphic ventricular tachycardia (CPVT)? | | |
| 13 | Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | | |

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

*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 of exam.*

**EL2**

Revised 2/25

Student's Full Name: _____ Date of Birth: ___ /___ /_____ School: _____

| BONE AND JOINT QUESTIONS | | Yes | No |
|---|---|---|---|
| 14 | Have you ever had a stress fracture? | | |
| 15 | Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | | |
| 16 | Do you have a bone, muscle, ligament, or joint injury that currently bothers you? | | |
| **MEDICAL QUESTIONS** | | **Yes** | **No** |
| 17 | Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma? | | |
| 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? | | |

| MEDICAL QUESTIONS *(continued)* | | Yes | No |
|---|---|---|---|
| 26 | Do you worry about your weight? | | |
| 27 | Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 28 | Are you on a special diet or do you avoid certain types of foods or food groups? | | |
| 29 | Have you ever had an eating disorder? | | |

Explain "Yes" answers here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

**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: ___ / ___ / ___

*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 of exam.*

**EL2**
Revised 2/25

## 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<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | | |
| Eyes, Ears, Nose, and Throat<br>• Pupils equal<br>• Hearing | | |
| Lymph Nodes | | |
| Heart<br>• Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver) | | |
| Lungs | | |
| Abdomen | | |
| Skin<br>• Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis | | |
| 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<br>• Double-leg squat test, single-leg squat test, and box drop or step drop test | | |

**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 #: _____

********** UPLOAD THIS PAGE ONLY **********

**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 of exam.*

**EL2**

Revised 2/25

## 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: (_____) _____

**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.

*** ☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction after clearance by medical specialist for:_____

*(If this option is checked, additional medical follow-up and clearnace prior to sports participation is required. Use EL2 Page 5 for documentation.)*

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

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

_____

In accordance with §1006.20(2)(c), F.S., I hereby certify that I am a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with my regulatory board and 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 #: _____

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

*** UPLOAD IF DOCTOR RECOMMENDED FURTHER EVALUATION***

**PREPARTICIPATION PHYSICAL EVALUATION** (Supplement)

*SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL*

*This form is valid for 365 calendar days from the date of exam.*

**EL2**

**Revised 2/25**

*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)*

**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA**

# Cardiology Report: Electrocardiogram (ECG) Finding

**(to be completed by a licensed physician)**

Parents: An ECG screen (also referred to as an EKG) can help identify young athletes who are at risk for sudden cardiac death, a condition where death results from an abrupt loss of heart function. An ECG screening may assist in diagnosing several different heart conditions that may contribute to sudden cardiac death. The School District is requiring one (1) cleared ECG, during a student's four (4) years of high school, to assure the health of any student participating in athletics.

Please have the reviewing physician fill out and sign this form and return to: _____ (Name of School)

Date: _____

Student's Name: _____

Sex: _____ Date of Birth: _____ Age: _____ Ethnicity: _____

Height: _____ Weight: _____

***ECG in office:***

Normal: _____ Abnormal: _____

## Cardiac Clearance

Name of Physician or Approved Health Care Professional Date: _____

_____ _____

(Print Name) (Signature)

Address: _____ City / St _____ Zip _____

Comments:

_____

_____

_____

# IMPACT BASELINE CONCUSSION

# TEST INSTRUCTIONS

1) Go to www.impacttestonline.com/testing
2) Must use laptop or computer to take test.
3) Please make sure you are taking the test in a quite area, without distractions (cellphone, TV, etc.).
4) Once you begin the test, you must finish it completely.
5) Enter customer I.D. Code: NRZ2BM6JIE and Validate
6) Click launch test.
7) Select Language.
8) When answering demographic questions read carefully. Common mistakes: Years of experience and years of school DO NOT count this school year as you have not completed it (ex. Sophomore will choose 9 since haven't completed 10th). If you take medicine and do not know what it is called, put what medical issue it is for. When asked about prior concussions, do not mark anything UNLESS A MEDICAL PHYSICAN has diagnosed you as such (ONLY VALID IF MEDICAL PHYSICIAN DIAGNOSIS), and if such diagnosis and you don't remember the exact date of diagnosis just guestimate. When entering current symptoms, mark NOT EXPERIENCING unless you have recently been diagnosed by a medical physician with a concussion.
9) **READ ALL INSTRUCTIONS CARFULLY AND MULTIPLE TIMES BEFORE TAKING SECTION OF TEST. BE AWARE SCORES ARE FOR ACCURACY, TIME, AND CORRECTNESS.**
10) MAKE SURE YOU SELECT THE SPORT YOUR PARTICIPATING IN WHEN ASKED
11) **AT THE END, PLEASE SEND CONFIRMATION EMAIL TO YOURSELF, THEN EXIT OUT OF WEBSITE /LOG OFF.**