ATHLETIC PARTICIPATION CHECKLIST

All the items below must be completed prior to tryouts or participation in sports.

Checklist

- ☐ Online Registration completed on Athletic Clearance.
- ☐ Updated Sports Physical (done within 365 days) uploaded onto Athletic Clearance.

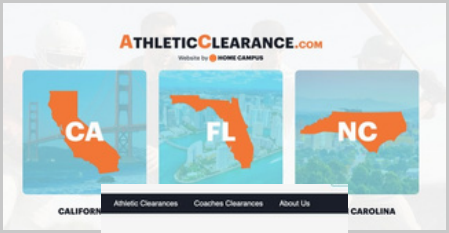
  Only pg. 4 with physician signature required for upload
- ☐ ECG Uploaded onto Athletic Clearance (only required 1st year of participation).
- ☐ Impact Baseline testing completed online.
- ☐ Athletic Participation Fee paid on Athletic Clearance (required upon making the team).

Important Notes:

- ☐ Paper copies of Athletic Physicals or ECG WILL NOT BE ACCEPTED. Only uploaded copies will be approved for participation.
- ☐ Documentation will be approved within 24-48 hours of upload. A student athlete is not cleared to participate until medically cleared.
- ☐ Payment of Athletic Participation Fee will result in free admission to any home athletic event for the 25-26 school year.

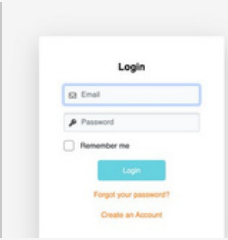
ONLINE ATHLETIC CLEARANCE

1 **VISIT ATHLETICCLEARANCE.COM**
CHOOSE FLORIDA
LLOGIINN TO AACCOUNT



Return Users
Log into existing account used in previous School Year.

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



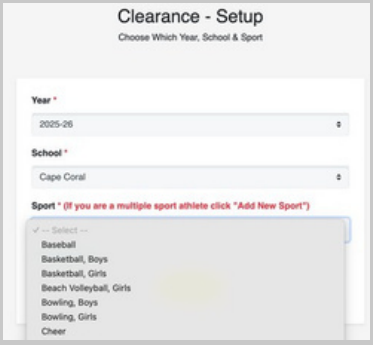
2 **SELECT START CLEARANCE HERE**

Select Year
Select School
Add Sports

Participating in multiple sports? Use Add New Sport button.

Need to add a Sport to an existing application? Click + Sport button and verify application data.

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



Student Info & Parent Guardian Info
Type in Student & Parent/Guardian Information. This information will be saved for future clearances. Utilize the drop down menu to autofill information for subsequent clearances.

Signatures
Sign required documents by typing in an **EXACT** match of what is on the Student & Parent/Guardian page.

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.

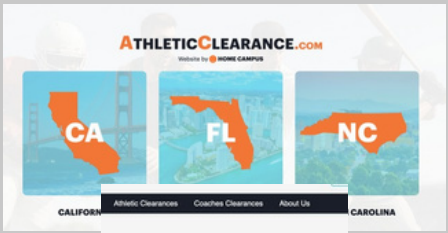
CONTACT HOME CAMPUS
SUPPORT@HOMECAMPUS.COM
ATHLETIC CLEARANCE HELP ARTICLES

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

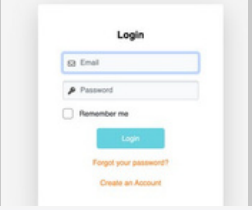
Help

ONLINE ATHLETIC CLEARANCE

1 VISITA ATHLETICCLEARANCE.COM
ELIGE FLORIDA
INICIAR SESIÓN EN LA CUENTA

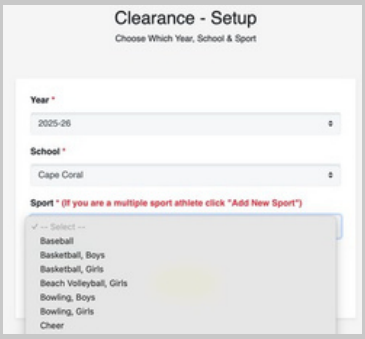


Usuarios nuevos
Crea una cuenta. Regístrese con una dirección de correo electrónico válida de PADRE/TUTOR como nombre de usuario y genere una contraseña.
Usuarios que regresan
Inicie sesión en la cuenta existente utilizada en el año escolar anterior.



2 SELECCIONAR AGREGAR NUEVA LIQUIDACIÓN

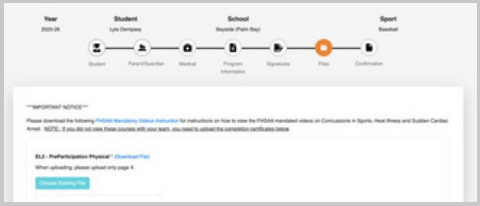
Seleccionar
Año escolar en el que el estudiante planea participar.
Escuela donde el estudiante participará Deporte(s).
¿Participa en múltiples deportes? Utilice el botón Agregar nuevo deporte.



3 COMPLETE TODOS LOS CAMPOS REQUERIDOS
Información del estudiante, información del padre/tutor, historial médico, formularios de firma y cargar cualquier archivo.

Información del estudiante e información de los padres y tutores
Si ha utilizado anteriormente la Autorización Atlética, seleccione estudiante o padre/tutor en el menú desplegable. La mayoría de los campos se completarán automáticamente con información anterior. Asegúrese de actualizar los campos que no se completan automáticamente.

Archivos
Arrastra y suelta o navega desde tu computadora para agregar un archivo. Seleccione Elegir archivo existente para buscar un archivo cargado anteriormente.



HACER CLIC ENVIAR SOLICITUD COMPLETA

4 MENSAJE DE CONFIRMACION

Su autorización estará lista para que su escuela la revise una vez que haya llegado a la página MENSAJE DE CONFIRMACIÓN.

¡EL ESTUDIANTE NO TIENE AUTORIZACIÓN AÚN!
LA ESCUELA DEBE REVISAR Y APROBAR AL ESTUDIANTE. SE ENVIARÁ UNA NOTIFICACIÓN POR CORREO ELECTRÓNICO UNA VEZ QUE LA ESCUELA HAYA REVISADO Y AUTORIZADO LA PARTICIPACIÓN DEL ESTUDIANTE.

CONTACTO HOME CAMPUS
SUPPORT@HOMECAMPUS.COM
HOMECAMPUS.COM

¿PREGUNTAS?
UTILICE EL ICONO DE AYUDA EN LA PANTALLA INFERIOR DERECHA PARA OBTENER AYUDA.

Help

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.

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 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 • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, Ears, Nose, and Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin • 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 • 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 #: _____

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.

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)*

To begin, go to www.impacttestonline.com/testing

1) Makesuretouseamouseorthetestwillcomebackinvalid.

2) Clicklaunchtest.

3) EntercustomerI.D.code:0DM5T0ZYI7(makesurelettersarecapitals).

4) Whenansweringdemographicquestionsreadcarefully.

a. **Commonmistakes:**YearsofexperienceandyearsofschoolDONOTcountthis school year as you have not completed it (ex. Sophomore will choose 9 since haven't completed 10th). If you take medicine and don't know what it is called, put what medical issue it is for.

b. Whenaskedaboutpriorconcussions,donotmarkanythingUNLESSAMEDICAL PHYSICIAN 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.

c. Whenenteringcurrentsymptoms,markNOTEXPERIENCINGunlessyouhave recently been diagnosed by a medical physician with a concussion.

5) READALLINSTRUCTIONSCARFULLYANDMULTIPLETIMESBEFORETAKINGSECTIONOFTEST. BE AWARE SCORES ARE FOR ACCURACY, TIME, AND CORRECTNESS.

6) AttheendyoudoNOTneedtosendemailtoyourself,justexitoutofwebsiteandorlogoff.

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)

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 conditio 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:

_____

_____

_____