Athletic Clearance Instructions

We are now conducting our athletic clearance online for participation in athletics at Harmony High School. Please follow the steps below, and **turn in the signed clearance form and physical to the athletic trainer or athletic office**. ***An athlete will not be permitted to participate until this task is complete***.

***Note**: You have the ability to scan and upload the physical. We ask that you bring in the actual physical with the Doctor's stamp and signature. Also, please turn in the form at the end of your clearance, signed by a parent/guardian and student.

- Visit www.athleticclearance.com, click the "FL" icon.
- If you have not used this system before, please register and follow the prompts. If you have, use your e-mail and password you set up. Having issues? Watch the video for more help.
- Click "Start Clearance Here!"
- Select the year (2020-2021), the school (Harmony), and the first sport your athlete is playing.
- Click "Submit". Only choose 1 sport. We will add additional sports later.
- If you have done this previously, find your athlete. For Student ID, DO NOT USE THE LEADING ZERO! (Example – 0123456, you'll put in "123456").
- If this athlete was not at Harmony High School last school year or on the first day of 9th grade, you'll have to fill out the "Affidavit of Compliance – GA4" (In packet below). You only have to do this one time!
- The next page is where you upload any forms. ***In most cases you don't need to upload anything*** as the physical and ECG will come directly to the trainer or AD. **Click "SAVE"**
- Follow along the answer questions at this point...if you answer "Yes", a box will drop down where you can explain. Click "Save".
- Parent/Guardian information is next. Please be specific as we may need this in an emergency situation. Click "Submit".
- Signatures...Both Parent/Guardian and Student will sign electronically on this page. The next part gives you an option to go ahead and pay the student's participation fees. You are NOT obligated to pay them at this time, but you can if you choose. This fee will need to be paid before an athlete is permitted to play in a contest.
- At the end, you will print out the final confirmation letter. Both Parent/Guardian and Student MUST sign and turn in to the athletic trainer or athletic office with your physical. We will not accept physicals that are not stamped and/or dated.

Reminder: Physical and clearance form must be turned in at the school. ECG must only be completed ONE TIME between grades 9-12.

Thank you!

HHS Longhorn Athletic Department

THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA

ATHLETIC PARTICIPATION – Preparticipation Physical Evaluation

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.

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	___ Upper Arm	___ Finger	___ Shin/Calf
___ Neck	___ Elbow	___ Foot	___ Ankle
___ Back	___ Forearm	___ Hip	
___ Chest	___ Wrist	___ Thigh	
___ Shoulder	___ Hand	___ Knee	

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:_____
Hepatitis 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: _____

THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA

ATHLETIC PARTICIPATION – Preparticipation Physical Evaluation

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 below.

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: _____

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.