



St. Cloud High School Athletic Clearance Instructions



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1. Visit AthleticClearance.com
 2. **Select Florida**
 3. **First Time Users:**
 - Create an Account. PARENTS/GUARDIANS will register with a valid email username and password.
 4. **Returning 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 2022-2023.
 - School at which the student attends and will compete
 - Sport/s (**We recommend that if the student will be participating in multiple sports, that those sports are added all at once. Choose all you are interested in participating!!**)
 8. Complete all required fields for Student Information, Parent/Guardian Information, Medical History, Signature Forms. ***DO NOT UPLOAD ANYTHING, TURN IN ORIGINAL DOCUMENTS WITH CONFIRMATION PAGE MENTIONED BELOW....***

(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.
 11. **Print out “Confirmation Page” and have both parent & student sign the form,** then turn form into Athletic Office with your eligibility packet.

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

OVER

This is the MOST important part.....

In order for your Athletic Packet to be accepted by the Athletics office, you must have the following 4 things all stapled together and ready to go. If you are missing ANY of the following, your packet will not be accepted!

The 4 things required to be TURNED IN:

- Your Online Clearance Confirmation page, both signed by the Student & Parent
- Your Physical, both pages (Sides) signed and stamped by your Physician
- Your confirmation sheet showing you have taken the Online Concussion test
- If you are a new athlete, or have never played sports here at SCHS, you will need your cleared ECG page signed off by your physician. If you have played sports here, and already have this in our files, you do not need this last part.

All of the information you need is in the packet...please use those forms provided!

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		Yes	No	
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___	26. Have you ever become ill from exercising in the heat?	___	___	
2. Do you have an ongoing chronic illness?	___	___	27. Do you cough, wheeze, or have trouble breathing during or after activity?	___	___	
3. Have you ever been hospitalized overnight?	___	___	28. Do you have asthma?	___	___	
4. Have you ever had surgery?	___	___	29. Do you have seasonal allergies that require medical treatment?	___	___	
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	___	___	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)?	___	___	
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	___	___	31. Have you had any problems with your eyes or vision?	___	___	
7. Do you have any allergies (for example, pollen, latex, medicine, food, or stinging insects)?	___	___	32. Do you wear glasses, contacts, or protective eyewear?	___	___	
8. Have you ever had a rash or hives develop during or after exercise?	___	___	33. Have you ever had a sprain, strain, or swelling after injury?	___	___	
9. Have you ever passed out during or after exercise?	___	___	34. Have you broken or fractured any bones or dislocated any joints?	___	___	
10. Have you ever been dizzy during or after exercise?	___	___	35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	___	___	
11. Have you ever had chest pain during or after exercise?	___	___	<i>If yes, check appropriate blank and explain below.</i>			
12. Do you get tired more quickly than your friends do during exercise?	___	___	___ Head	___ Upper Arm	___ Finger	___ Shin/Calf
13. Have you ever had racing of your heart or skipped heartbeats?	___	___	___ Neck	___ Elbow	___ Foot	___ Ankle
14. Have you had high blood pressure or high cholesterol?	___	___	___ Back	___ Forearm	___ Hip	
15. Have you ever been told you have a heart murmur?	___	___	___ Chest	___ Wrist	___ Thigh	
16. Has any family member or relative died of heart problems or sudden death before age 50?	___	___	___ Shoulder	___ Hand	___ Knee	
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___	36. Do you want to weigh more or less than you do now?	___	___	
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___	37. Do you lose weight regularly to meet weight requirements for your sport?	___	___	
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)?	___	___	38. Do you feel stressed out?	___	___	
20. Have you ever had a head injury or concussion?	___	___	39. Have you ever been diagnosed with sickle cell anemia?	___	___	
21. Have you ever been knocked out, become unconscious, or lost your memory?	___	___	40. Have you ever been diagnosed with having the sickle cell trait?	___	___	
22. Have you ever had a seizure?	___	___	41. Record the dates of your most recent immunizations (shots) for:			
23. Do you have frequent or severe headaches?	___	___	Tetanus: _____	Measles: _____		
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	___	___	Hepatitis B: _____	Chickenpox: _____		
25. Have you ever had a stinger, burner, or pinched nerve?	___	___	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.

While students are waiting for their computers to log-on, please make sure that they turn their cell phones off or on silent, no headphones/ear buds/music, no photography or paper & pencil to write down information.

Also advise them to stay together as there are a few confusing questions and certain areas you can skip.

ImPACT Baseline Test Instructions

ImPACT is a computer-based neurocognitive testing tool used in the management of mild traumatic brain injuries (mTBI), more commonly known as concussions. You are being asked to take a baseline test, so that in the event you sustain a concussion or an injury with a mechanism that suggests a concussion, we may be able to evaluate and assess the severity of the injury and the progress of your recovery.

It is in your best interest to produce an honest effort in taking this baseline test, such that we have a valid baseline scores against which to measure in the event of a head injury. If you do poorly or produce a test with invalid results, you will be asked to retake the test in a supervised environment. Additionally, we will be required to manage your care in a much more conservative approach, likely leading to a greater loss of participation time.

Instructions:

1. Login to the computers. **Use Google Chrome**
2. Go to <https://www.impacttestonline.com/testing>
3. Enter Customer Code **FF0Y2TLL9N**
4. Click on “**Launch Baseline Test.**” Follow the prompts and questions...pay attention to anywhere it asks for “years complete” if they are going into 11th grade, they have completed 10 years of education.
5. No need to put in address...skip it.
6. If the system won't let them continue, there is something wrong like a wrong date or something. Look for it.
7. Complete the test.
8. The last page asks to print out or email...**print it out and turn it in with your Athletic Packet.**

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

Cleared without limitations: _____

Not Cleared: _____

Name of Physician or Approved Health Care Professional

Date: _____

(Print Name)

(Signature)

Address: _____

City / St _____ Zip _____

Comments:

