

## 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 1<sup>st</sup> 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

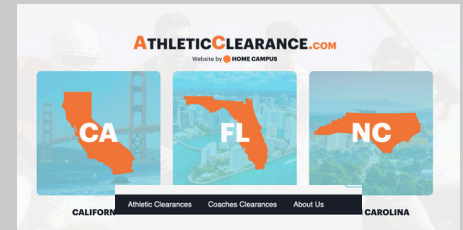
## 1 VISIT [ATHLETICCLEARANCE.COM](https://athleticclearance.com) CHOOSE FLORIDA LOGIN TO ACCOUNT

### 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

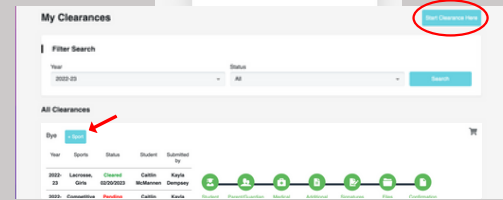
Select Year

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

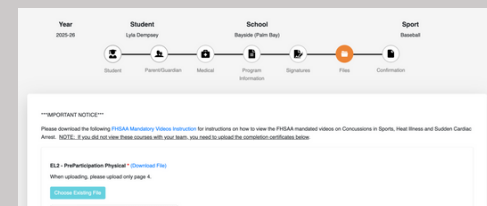
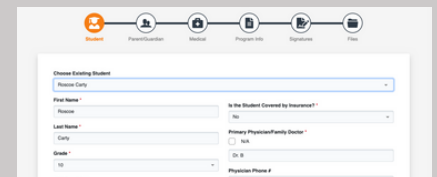
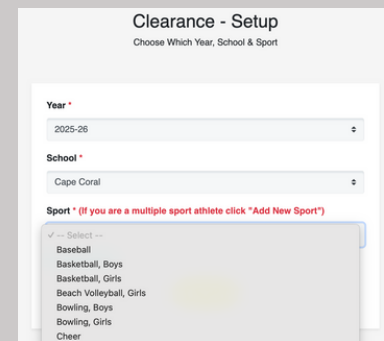
Type in Student & Parent/Guardian Information. This information will be saved for future clearances. Utilize the drop down menu to autofill information for subsequent clearances.

### 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.



## 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.**

# ONLINE ATHLETIC CLEARANCE

## 1 VISITA [ATHLETICCLEARANCE.COM](https://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.

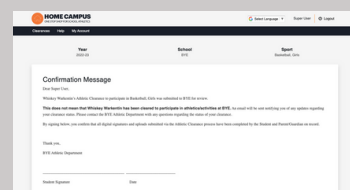
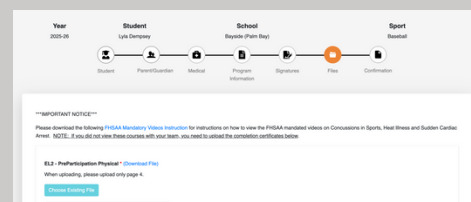
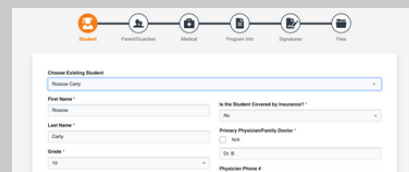
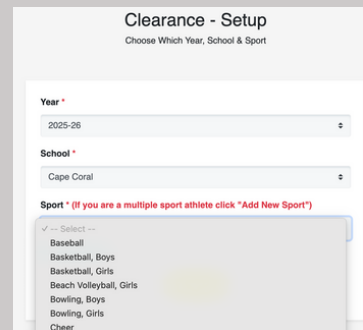
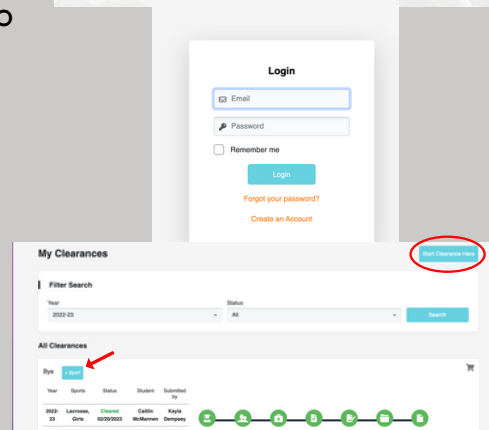
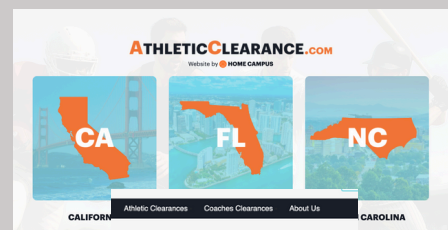
### Archivos

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](mailto:SUPPORT@HOMECAMPUS.COM)  
[HOMECAMPUS.COM](https://HOMECAMPUS.COM)

### ¿PREGUNTAS?

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

Help

### ImPact Baseline Testing Instructions

- 1) Go to [www.impacttestonline.com/testing](http://www.impacttestonline.com/testing)
- 2) Make sure to use a mouse or the test will come back invalid
- 3) Click launch test. **ODM5T0ZYI7**
- 4) Enter customer I.D. code: [REDACTED] (ID code is case sensitive & all letters are capital).
- 5) 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 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. When entering current symptoms, mark NOT EXPERIENCING unless you have recently been diagnosed by a medical physician with a concussion.
- 6) READ ALL INSTRUCTIONS CAREFULLY AND MULTIPLE TIMES BEFORE TAKING SECTION OF TEST. BE AWARE SCORES ARE FOR ACCURACY, TIME, AND CORRECTNESS.
- 7) MAKE SURE YOU SELECT THE SPORT YOUR PARTICIPATING IN WHEN ASKED
- 8) At the end please send email to yourself, then exit out of website and or logoff.
- 9) Any problems please contact the Athletic Department.

Please complete this ASAP as you are not eligible to participate in tryouts/practice/games unless complete



**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<br>(continued) |   | Yes | No |
|--|--|-----|----|---|---|-----|----|
| Explain "Yes" answers at the end of this form.<br>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.  
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**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:<br><br>_____<br><br>_____<br><br>_____<br><br>_____<br><br>_____<br><br>_____ |  |     |    |
| 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.

|  |   |
|--|---|
| <ul style="list-style-type: none"><li>Do you feel stressed out or under a lot of pressure?</li></ul>   | <ul style="list-style-type: none"><li>Do you ever feel sad, hopeless, depressed, or anxious?</li></ul>  |
| <ul style="list-style-type: none"><li>Do you feel safe at your home or residence?</li></ul>  | <ul style="list-style-type: none"><li>During the past 30 days, did you use chewing tobacco, snuff, or dip?</li></ul>  |
| <ul style="list-style-type: none"><li>Do you drink alcohol or use any other drugs?</li></ul>   | <ul style="list-style-type: none"><li>Have you ever taken anabolic steroids or used any other performance-enhancing supplement?</li></ul>                             |
| <ul style="list-style-type: none"><li>Have you ever taken any supplements to help you gain or lose weight or improve your performance?</li></ul> | <ul style="list-style-type: none"><li>Have you experienced performance changes, felt fatigued, and/or experienced times of low energy during the past year?</li></ul> |

- ☐ 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 |
| <b>MEDICAL - healthcare professional shall initial each assessment</b>   | <b>NORMAL</b> | <b>ABNORMAL FINDINGS</b>                      |
| 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   |               |   |
| <b>MUSCULOSKELETAL - healthcare professional shall initial each assessment</b>   | <b>NORMAL</b> | <b>ABNORMAL FINDINGS</b>                      |
| 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)*

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:

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