

**2023-2024 FHSAA Physical Packet**  
**Cypress Creek Middle School**  
**6<sup>th</sup>-8<sup>th</sup> Grade**

\*The FHSAA physical packet for the 2023-2024 school year must be completed using [www.athleticclearance.com](http://www.athleticclearance.com). Instructions for uploading the necessary documents are enclosed in this packet. Please see the list below for items that will need to be uploaded prior to a clearance being granted.

Forms to upload:

- ▶ FHSAA EL2 w/ Doctors Signature and Date
- ▶ Notary Page
- ▶ DSBPC Sportsmanship Form
- ▶ NFHS Concussion in Sports
- ▶ NFHS Heat Illness
- ▶ NFHS Sudden Cardiac Arrest



## ATHLETIC CLEARANCE

*Quick steps for parents/students using the online athletic clearance process.*

### Online Athletic Clearance – Uploading Athletic Paperwork

1. Visit [AthleticClearance.com](http://AthleticClearance.com)
2. **Select Florida**
3. **First Time Users:**
  - **Create an Account.** PARENTS/GUARDIANS will register with a valid email username and password.
4. **Return 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 in which the student plans to participate. *Example: Football in Aug 2022 would be the 2022-2023 School Year.*
  - School at which the student attends and will compete at
  - Sport/s (*We recommend that if the student will be participating in multiple sports, that those sports are added all at once, if available*)
8. Complete all required fields for Student Information, Parent/Guardian Information, Medical History, Signature Forms and upload a File if applicable. (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.

## **Online Athletic Clearance FAQ**

### **What is my Username?**

Your username is the email address that you registered with.

### **How do I register for multiple Sports?**

If you know you are going to play multiple sports when registering, it is best to add all sports on the first step where you also select the school year and school. If you are registering for additional sports after completing your initial clearance for the year, you will have to complete the process again. The good news is that if you select the student & parent/guardian info from the dropdown on those respective pages, the information will autofill.

### **Physicals**

The physical form your school uses can be downloaded on Medical History page. Most schools will accept the physical online (done by uploading the completed form on the Files page) as well as turning in a hard copy to the athletic department.

### **Your Files**

This area is meant to store your files so they can be accessed later in the year or perhaps years following.

### **Why haven't I been cleared?**

Your school will review the information you have submitted before clearing you for participation. Once they review your clearance they will change the status. You will receive an email when you have been cleared for participation

### **My sport is not listed!**

Please contact your school's athletic department and ask for your sport to be activated.

**I was "Denied" clearance, now what?** You should have received an email with the reason for denial. Please update your clearance accordingly then contact your school's athletic department and ask them to review your information again.



# Pasco County Schools

Kurt S. Browning, Superintendent of Schools  
7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638

## ATHLETIC PARTICIPATION FORM

PLEASE CLEARLY PRINT OR TYPE:

GRADE LEVEL/SCHOOL YEAR: \_\_\_\_\_ STUDENT I. D. #: \_\_\_\_\_

*Name of Student (As it appears on the student's birth certificate):*

**LAST** \_\_\_\_\_ **FIRST** \_\_\_\_\_ **MIDDLE** \_\_\_\_\_

STUDENT ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_

HOME PHONE (WITH AREA CODE): \_\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

NAME OF LAST SCHOOL ATTENDED/YEAR: \_\_\_\_\_

**FATHER/GUARDIAN:** \_\_\_\_\_

STREET/P.O. BOX \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_

EMPLOYER'S NAME \_\_\_\_\_ EMPLOYER'S PHONE (\_\_\_\_) \_\_\_\_\_

MEDICAL INSURANCE COMPANY \_\_\_\_\_ MEMBER ID # \_\_\_\_\_

**MOTHER/GUARDIAN:** \_\_\_\_\_

STREET/P.O. BOX \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_

EMPLOYER'S NAME \_\_\_\_\_ EMPLOYER'S PHONE (\_\_\_\_) \_\_\_\_\_

MEDICAL INSURANCE COMPANY \_\_\_\_\_ MEMBER ID # \_\_\_\_\_

Is the company or plan listed above considered a Health Maintenance Organization (HMO)? YES: \_\_\_\_\_ NO: \_\_\_\_\_

Participation in competitive athletics may result in severe injury, including paralysis or death. Improvements in equipment, medical treatment, and physical conditioning, as well as rule changes, have reduced these risks, but it is impossible to totally eliminate such occurrences from athletics.

**PARENT STATEMENT:** The undersigned parent(s)/guardian(s) gives consent for the athlete identified herein to travel with the team as a member on its trips. I/We, the undersigned parent(s)/guardian(s) of the above-named student or above-named adult student, do hereby consent to the release of confidential educational records/data including, but not limited to: student's name, date of birth, attendance, grades and such other confidential student data as is necessary for the determination of eligibility for participation in activities regulated by FHSAA to FHSAA and its service provider Home Campus, Inc. and MaxPreps. The information shall be used solely for the purpose of determining and reporting eligibility to participate in athletics. I/We further authorize the release of student transcripts by FHSAA and/or Home Campus to colleges/universities or their representatives for recruiting purposes regarding the above-named or to the District School Board of Pasco County, Florida and its constituent schools. No other re-disclosure of the records/date provided under this consent is authorized.

**INSURANCE:** The District School Board of Pasco County provides only secondary student athletic insurance coverage, but this IS NOT a guarantee of payment for medical services. You may encounter certain out-of-pocket expenses when your son or daughter is treated for accidental injuries.

**BIRTH CERTIFICATE:** Each athlete MUST present to the athletic director or coach a certified copy of a valid birth certificate. The copy will be returned.

**IN THE EVENT OF AN INJURY AND YOU CANNOT BE REACHED, DO YOU GIVE HIS/HER COACH PERMISSION TO HAVE YOUR CHILD TREATED MEDICALLY? YES: \_\_\_\_\_ NO: \_\_\_\_\_**

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

STATE OF FLORIDA, COUNTY OF \_\_\_\_\_ The foregoing instrument was acknowledged before me via ☐ physical presence OR ☐ online notarizations on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_, who is personally known to me or produced \_\_\_\_\_ as identification.

Signature of Notary \_\_\_\_\_

NOTARY SEAL

Printed Name of Notary \_\_\_\_\_

My Commission Expires \_\_\_\_\_



# Pasco County Schools

Kurt S. Browning, Superintendent of Schools

7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638

## Pasco County Schools Athletic Information for Students and Parents

**ACADEMIC ELIGIBILITY:** In order to participate in high school interscholastic athletics, a student must currently have and maintain a cumulative grade point average of 2.0 or above on a 4.0 un-weighted scale. The athletic director and/or coach will verify all grades within a five-day period subsequent to team tryouts. Failure to have and maintain a cumulative 2.0 grade point average will result in immediate dismissal from any interscholastic athletic team. Middle school students must have a 2.0 grade point average for the previous semester in order to be eligible.

**ATHLETIC TRANSFER VERIFICATION:** Any middle or high school student who has been *authorized* to transfer from one school to another must meet the athletic transfer verification requirements. This includes, but is not limited to, students who were previously enrolled in public schools, private schools, charter schools, home schools, magnet schools and alternative schools. For more information on this procedure, visit your school or district athletic website or contact your school athletic director. The verification policy/procedures can be located at the following web address:  
<http://www.neola.com/pasco-fl/>

**ATHLETIC FEES:** There are no try-out fees. Once a student is selected for a team a fee will be due: \$70.00 for high school students; \$50.00 for middle school students. The fee for the second sport is \$40.00 for high schools; \$30.00 for middle schools. The total family fee (for the same school) is \$180.00 for high schools; \$130.00 for middle schools. The individual cap for high schools is \$110.00. The individual cap for middle schools is \$80.00. A student will not be allowed to dress out, participate in a game or be considered part of the team until the full fee is paid. **ALL FEES MUST BE PAID WITHIN 3 DAYS OF THE CONCLUSION OF TRYOUTS.**

**STUDENT STATEMENT:** As a student athlete, I agree to maintain athletic eligibility, comply with training rules, and conduct myself so as to bring pride to my school, my team, and my family. I understand I, as well as my parent(s)/guardian(s), are responsible for any uniforms, equipment, and / or supplies issued to me while participating in interscholastic athletics. I agree to repair or replace any damaged item and replace any lost item. I understand suspension from school, in or out, will result in suspension from practices or games during the time of the suspension.

**EVENT SECURITY PROCEDURES:** All bags are subject to search upon entry. Bags and items not permitted on Pasco County Schools property must be returned to the patron's vehicle. **ONLY clear plastic, clear vinyl, or clear Ziploc bags** are permitted inside an event venue. Student athletes are permitted to bring bags. These bags are subject to search. Small clutch or wallet style bags no larger than 4 inches by 6 inches are permitted for entry but will be subject to search. All other styles of bags such as backpacks, fanny packs, purses and duffle bags are not permitted. An exception will be made for medically necessary items, diaper bags, and properly credentialed school and professional photographers' camera bags. These bags will be subject to search prior to entry, unless the item meets the clear bag guidelines. Please refer to the "Event Security Procedures" document on the district website for more details pertaining to this countywide policy.

**PAYMENT OF FHSAA FINES:** As a student athlete I am representing my school and my school district. I am responsible for my conduct in the athletic program. I will follow guidelines and rules outlined in the District School Board of Pasco County's Code of Student Conduct, Security Procedures and the FHSAA Handbook. In the event of an ejection or disqualification while participating in athletics my parent(s)/guardian(s) and I agree to pay the FHSAA fines, which are assessed by the FHSAA (Example: \$250.00 gross unsportsmanlike conduct).

My parent(s)/guardian(s) and I understand I won't be able to participate in any athletic contests until all fees have been paid to my school and I am subject to additional disciplinary action by any school administration depending on the severity of my actions.

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Student Number

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



## Code of Conduct at Sporting Events

**We expect our athletes, parents, and fans to show respect to other teams, officials, and other fans at all times.**

**We will not tolerate fighting, yelling, or cursing at officials, other fans, or the other team at both home and away athletic contests.**

### Code of Conduct Expectations:

1. Use of alcohol/alcoholic beverages, illegal drugs, smoking, vaping, and/or use of e-cigarettes on school premises is prohibited.
2. Do not argue with or criticize the players, cheerleaders, coaches, or officials in front of spectators by word of mouth or gesture. If you do not have something positive to say, do not say it.
3. Do not use abusive or profane language during any athletic contests or activities.
4. Do not physically or verbally abuse anyone (athlete or coach) in the athletic program.
5. Do not incite unsportsmanlike conduct, to include melee or unrest at an event.
6. Do not seek to undermine school officials through word of mouth or deed.
7. Do always set an example by your personal conduct in front of all persons connected with the school programs.
8. Do remember that winning at all costs is not a message we wish to impart to our youth. Instead, we want them to have fun, to play safe, and to encourage sportsmanship.
9. Parents/Guardians: By not agreeing to and signing this Code of Conduct contract, you have elected not to participate with your child/children in the school athletic programs.

**The violation of any portion of these expectations relating to this Code of Conduct may result in removal from the event or:**

### PENALTIES

1. **Adults:** Removal from attendance at athletic events and potential for trespass from school/district campus
2. **Students:** The participating student who is in violation of rule or rules contained in this Code of Conduct may be suspended from the team for a game or multiple games; may be placed on probation; may have school consequences assigned and may face penalties from the FHSAA.

By acknowledging these expectations with your signature or on [athleticclearance.com](http://athleticclearance.com), it is known that this form was read and agreed to by the parent and athlete.

Date: \_\_\_\_\_

\_\_\_\_\_  
Parent Name

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Student Signature



**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 4/23

**MEDICAL HISTORY FORM**

**Student Information** (to be completed by student and parent) *print legibly*

Student's Full Name: \_\_\_\_\_ Sex Assigned at Birth: \_\_\_\_\_ 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               |

|                                                                                                                              |                                                                                                    |     |    |
|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-----|----|
| <b>GENERAL QUESTIONS</b><br>Explain "Yes" answers at the end of this form.<br>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?                                        |     |    |
| <b>HEART HEALTH QUESTIONS ABOUT YOU</b>                                                                                      |                                                                                                    | 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?                                       |     |    |

|                                                        |                                                                                                                                                                                                                                                                                                                   |     |    |
|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| <b>HEART HEALTH QUESTIONS ABOUT YOU</b><br>(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?                                                                                                                                                                                                                                                                                      |     |    |
| <b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>        |                                                                                                                                                                                                                                                                                                                   | 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 catecholaminergic 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.  
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**EL2**

Revised 4/23

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: \_\_\_\_/\_\_\_\_/\_\_\_\_





**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 4/23

**PHYSICAL EXAMINATION FORM**

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ School: \_\_\_\_\_

**PHYSICIAN 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? |                                                                                             |

- ☐ 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 <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                                                                                                                                                                                                                   |             |                                               |
| 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 <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 4/23

### MEDICAL ELIGIBILITY FORM

#### Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: \_\_\_\_\_ Sex Assigned at Birth: \_\_\_\_\_ 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: (\_\_\_\_) \_\_\_\_\_

- ☐ 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 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 4/23

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: \_\_\_\_\_ Sex Assigned at Birth: \_\_\_\_\_ 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)*



As per FHSAA Policies **40.1.1**, **41.1** and **42.1.1**, all student-athletes are required to watch the following **FREE** NFHS Learn courses annually.

- Concussion In Sports – What You Need to Know
- Heat Illness Prevention
- Sudden Cardiac Arrest

### **Course Ordering**

**Step 1:** Go to [www.nfhslearn.com](http://www.nfhslearn.com).

**Step 2:** **"Sign In"** to your account using the e-mail address and password you provided at time of registering for an nfhslearn account.

OR

If you do not have an account, **"Register"** for an account.

**Step 3:** Click **"Courses"** at the top of the page.

**Step 4:** Scroll down to the specific course from the list of courses.

**Step 5:** Click **"View Course"**.

**Step 6:** Click **"Order Course."**

**Step 7:** Select **"Myself"** if the course will be completed by you.

**Step 8:** Click **"Continue"** and follow the on-screen prompts to finish the checkout process. (Note: There is no fee for these courses.)

### **Beginning a Course**

**Step 1:** Go to [www.nfhslearn.com](http://www.nfhslearn.com).

**Step 2:** **"Sign In"** to your account using the e-mail address and password you provided at time of registering for an nfhslearn account.

**Step 3:** From your **"Dashboard,"** click **"My Courses"**.

**Step 4:** Click **"Begin Course"** on the course you wish to take.

For help viewing the course, please contact the help desk at NFHS. There is a tab on the upper right hand corner of [www.nfhslearn.com](http://www.nfhslearn.com). If you should experience any issues while taking the course, please contact the NFHS Help Desk at (317) 565-2023.