

**2024-2025 FHSAA Physical Packet**  
**Cypress Creek Middle School**  
**6<sup>th</sup>-8<sup>th</sup> Grade**

\*The FHSAA physical packet for the 2024-2025 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.

FHSAA EL2 w/ Doctor, Parent, and Student Signatures and Exam Date (Page 4)

NFHS Concussion in Sports Certificate

NFHS Heat Illness Certificate

NFHS Sudden Cardiac Arrest Certificate

Transportation Release Form



## 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/data provided under this consent is authorized.

**INSURANCE:** As a service, Pasco County Schools provides a group insurance plan through Bollinger that is underwritten by Mutual of Omaha Insurance Company to assist families with some of the medical expenses that may result from a school sponsored and supervised activity. This coverage is available for all students/athletes and is subject to policy conditions, exclusions and maximums. This plan pays in excess of any in force insurance plan for the student and does not cover students if injured outside of school. If you have questions about the group plan, please contact [RiskManagement@pasco.k12.fl.us](mailto:RiskManagement@pasco.k12.fl.us)

**BIRTH CERTIFICATE:** Each athlete MUST upload 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 OR CERTIFIED ATHLETIC TRAINER PERMISSION TO HAVE YOUR CHILD TREATED MEDICALLY? YES: \_\_\_\_\_ NO: \_\_\_\_\_**

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**COPIES OF ALL PASCO COUNTY/FHSAA ATHLETIC FORMS MUST BE UPLOADED INTO YOUR ATHLETICCLEARANCE.COM ACCOUNT BEFORE YOUR TRYOUTS AT YOUR SCHOOL. PASCO COUNTY SCHOOLS WILL NOT ACCEPT HARDCOPY PAPERWORK HANDED IN TO THE COACH, ATHLETIC DIRECTOR, OR FRONT OFFICE STAFF.**



## 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		Yes	No
Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.				(continued)			
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.  
This form is valid for 365 calendar days from the date signed below

**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: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____			
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: \_\_\_/\_\_\_/\_\_\_

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**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.

• Do you feel stressed out or under a lot of pressure?	• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Do you drink alcohol or use any other drugs?	• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	• Have you experienced performance changes, felt fatigued, and/or experienced times of low energy during the past year?

Verify completion of FHSAA EL2 Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. (check box if complete)

EXAMINATION		
Height: _____	Weight: _____	
BP: ___/___ ( ___/___ )	Pulse: _____	Vision: R 20/___ L 20/___ Corrected: Yes No
MEDICAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, Ears, Nose, and Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and Arm		
Elbow and Forearm		
Wrist, Hand, and Fingers		
Hip and Thigh		
Knee		
Leg and Ankle		
Foot and Toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

**This form is not considered valid unless all sections are complete.**

\*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. The FHSAA Sports Medicine Advisory Committee strongly recommends to a student-athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.

Name of Healthcare Professional (print or type): \_\_\_\_\_ Date of Exam: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Signature of Healthcare Professional: \_\_\_\_\_ Credentials: \_\_\_\_\_ License #: \_\_\_\_\_

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# Submit to Athletic Clearance



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.



## 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 1/24

*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)*

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- Medically eligible for only certain sports as listed below:

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- 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)*



LEARNING  
CENTER

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.