Athletic Participation Forms

ALL ATHLETIC FORMS ARE NOW COMPLETED ONLINE BY PARENTS/GUARDIANS- We will not accept participation packets anymore. Parents need follow instructions below to input everything and to download the completed physical and notary form all on athleticclearances.com. **Coaches will not collect paperwork**. This must be completed before attending tryouts or practice. If you are having problems filling out the athletic clearance direct questions to the help chat on the website – please do not call the Coach or Athletic Director as they cannot control the site. Once you have completed the signup it will say "pending" – the Athletic Director will be approving athletes twice a week. If your account says" in progress" you have not completed all the steps by parent and athlete. No athlete will be allowed to participate without an account and completed paperwork.

Before attending any conditioning or tryouts, you MUST create an account on https://athleticclearance.com – the following are the MUST HAVE forms…detailed instructions follow.

You will need to have completed by a doctor the FHSAA EL2 all three pages. This must have the athletes name. This must be signed and dated by the doctor. It must be checked where it says cleared without limitations. If any of this is not filled out the clearance will be denied and your athlete will not be able to participate until completed correctly.

You will also need to have filled out and notarized the Pasco County Participation Form.

All forms and further information can be found at:
https://www.pasco.k12.fl.us/athletics/page/forms/

THESE ARE THE ONLY TWO FORMS NEEDED TO COMPLETE THE ATHLETIC CLEARANCE.

DETAILED INSTRUCTIONS

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

1. Visit athleticclearance.com. Click on the Florida Picture
2. Click on "**Create an Account**" and follow steps. Or sign in if you have previously created an account. Watch tutorial video if help is needed.
3. **Register**. PARENTS register with valid email username and password
4. Login using your email address that you registered with
5. Select "**Start Clearance Here**" to start the process.
6. Choose the School Year in which the student plans to participate. *Example: Football in Sept 2021 would be the 2021-2022 School Year.*
   Choose the School at which the student attends and will compete for.

Choose Sport. *You can also "Add New Sport" if a multi-sport athlete. Electronic signatures will be applied to the additional sports/activities.

7. Complete all required fields for Student Information, Educational History, Medical History and Signature Forms. **(If you have gone through the AthleticClearance.com process before, you will select the Student and Parent/Guardian from the dropdown menu on those pages)**
8. Once you reach the **Confirmation Message** you have completed the process.
9. All of 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.

Multiple Sports
On the first step of the process you have the ability to "Add New Sport". If you use this option, you fill out the clearance one time and it is applied to the sport selected. If you complete a clearance and come back at a later date to add a sport, you will "Start New Clearance" and then autofill student and parent information using the dropdown menus on those pages.

Physicals
The physical form can be downloaded on Files page.

Why haven't I been cleared?
Your school will review the information you have submitted and Clear, Clear for Practice or Deny your student for participation. You will receive an email when the student's status is updated.

My sport is not listed!
Please contact your school's athletic department and ask for your sport to be activated.

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; $125.00 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.

NO Tryout Fee: Students have three (3) days to pay fees after they make the team. No one will participate in game competition until fees have been paid. Please be aware that the participation fee does not guarantee playing time, only the opportunity to be on the team if selected.

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: 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 _____

Printed Name of Notary _____

My Commission Expires _____

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 3/23

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 Questionaire 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 Explain "Yes" answers at the end of this form. 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?		
	HEART HEALTH QUESTIONS ABOUT YOU	**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?		

	HEART HEALTH QUESTIONS ABOUT YOU *(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?		
	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**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.

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 3/23

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: ___/___/___

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 3/23

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 • 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 #: _____

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 3/23

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: ___/___/_____

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 3/23

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: ___ / ___ / _____
Address: _____ Phone: (_____) _____
Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*