Athletic Training Program:
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25-26 Physical Online Submission Instructions

All Sports, JROTC, Comp. Dance Teams, Marching Band and Guard

Important Information:

- **Processing Time:** Allow up to 2 school days for processing paperwork (2-3 weeks in summer). Same-day clearance is not possible.
- **Annual Clearance:** Online clearance is required at the beginning of each school year, even if the physical is still valid. Consent forms must be digitally signed, and medical information updated annually.
- **Resources:** See the WPHS Athletic Website for physical exam information and ECG locations.

Required Forms:

1. **FHSAA EL2 Preparticipation Physical Exam:**
   - Required annually, valid for 365 days.
   - Form: https://fhsaa.com/documents/2023/3/3/EL2_Form.pdf

2. **OCPS Cardiology Report: ECG Clearance:**
   - Required once before participation, valid throughout high school. ECG valid for 4 years of high school needs to be dated April of freshman year or later.
   - Form: https://tinyurl.com/OCPSCardiologyReport
   - Parents complete the top portion. For ECGs by Who We Play For, submit their email; all others use the OCPS Cardiology Report Form.

3. **All athletes must submit certificates for the NFHS required courses.** See below for more information. These must be completed annually.

Important Note: Keep hard copies of all forms. The ECG is valid for 4 years but must be uploaded each year with the physical.

Online Physical Submission Instructions:

1. Go to https://athleticclearance.fhsaahome.org/
   - **First-Time Users:** Create an account with a valid parent/guardian email and password (parent/guardian email MUST be used).
   - **Returning Users:** Enter login information. Use the same account to retain prior information (e.g., ECG Date).
2. Sign in with your parent/guardian email.
3. Select "Start Clearance Here or Add New Clearance."
4. Choose:
   - School Year: 2025-2026
   - School: Winter Park High School
   - Sports: Select ALL potential sports (harder to add later).
5. Complete all fields: Student Information, Parent/Guardian Information, Medical History, Signature Forms (exact match to previous information, case-sensitive).

6. **Upload Required Forms:**
   - **Physical on FHSAA EL2 (NEW FORM REVISED 2/25):** Upload Page 4 (and Page 5 if referred). Ensure completeness: parent/student signatures, doctor's date/signature, and doctor's office stamp with address.
   - **OCPS Cardiology Report: ECG Clearance:** This form MUST be filled out. Parents complete the top portion. Submit the Who We Play For email if applicable; otherwise, use the OCPS Cardiology Report Form.
7. Click "Submit Your Completed Registration."
8. **Clearance Process:** The student is not yet cleared. The WPHS Athletic Training Department will review the submission.
9. You will receive an email notification from Athletic Clearance once the student is cleared.
10. **Processing Time Reminder:** Allow up to 2 school days for processing.
11. **Questions:** Use the yellow "Help" option at the bottom right of the screen.

Online Athletic Clearance FAQ

- **Username:** Your email address used for registration.
- **Existing Clearance:** It's stored as a "folder" for that year; you can access it to upload files.
- **Multiple Sports:** Add all sports during initial registration. Adding later requires a new clearance.
- **Denial of Clearance:** Check your email for reasons and update accordingly. Contact the Athletic Training Department if not reviewed after 2 school days.
- **Clearance Status:** The school will review and update the status; you'll receive an email when cleared.
- **Form Copies:** Keep hard copies. The ECG is valid for 4 years but must be uploaded yearly with the physical. Download the physical form from the Medical History page or get copies from the WPHS 9th Grade Center or Main Campus front office.
- **File Storage & Help:** Uploaded files are stored for future access. Use the yellow "Help" option at the bottom right for assistance.

As per FHSAA Policy, all student-athletes are required to annually complete the following NFHS Learn courses before participation. All courses are FREE.

Required Courses:

- **Heat Illness Prevention**
- **Concussion for Students**
- **Sudden Cardiac Arrest**
- **Sportsmanship **NEW REQUIREMENT FOR 25-26****

Course Ordering

Step 1: Go to 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 under the students name. Each student must have their own individual account under their name.

Step 3: In the search bar, type in each course.

Step 4: Select "*Myself*"

Step 5: Select "*Florida*"

Step 6: Select "*Start Learning*"

Step 7: Courses will be added to your dashboard under "*My Courses*"

Step 8: Select "*Begin Course*"

Submitting a Certificate

Step 1: Go to www.nfhslearn.com

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

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

Step 4: Locate the course, click on "*Download Certificate*"

Step 5: Submit the downloaded file into Athletic Clearance under its corresponding location in the file upload section.

Certificates must have the students name on them. Certificates with any other name will not be accepted. Completion of courses is an annual requirement. They must be completed every school year for clearance.

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 of exam.

EL2

Revised 2/25

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 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 catecholaminerigc 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 of exam.

EL2

Revised 2/25

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 of exam.

EL2
Revised 2/25

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 #: _____

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 of exam.

EL2
Revised 2/25

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: (_____) _____

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 *(REQUIRED BY OCPS)*

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.

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction after clearance by medical specialist for:_____

(If this option is checked, additional medical follow-up and clearnace prior to sports participation is required. Use EL2 Page 5 for documentation.)

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

_____

In accordance with §1006.20(2)(c), F.S., I hereby certify that I am a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with my regulatory board and 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 #: _____

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 of exam.

EL2
Revised 2/25

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

MEDICAL ELIGIBILITY FORM - Referred Provider Form

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

Student's Full Name: _____ Biological Sex: _____ Age: _____ Date of Birth: ___ /___ /_____
School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____ Home Phone: (_____) _____
Name of Parent/Guardian: _____ E-mail: _____
Person to Contact in Case of Emergency: _____ Relationship to Student: _____
Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____
Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

Referred for: _____ Diagnosis: _____

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

☐ Medically eligible for all sports without restriction as of the date signed below

☐ Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Further Recommendations: *(use additional sheet, if necessary)*

_____

Name of Healthcare Professional (print or type): _____ Date of Exam: ___ / ___ / _____
Address: _____ Phone: (_____) _____
Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*

CARDIOLOGY REPORT: ELECTROCARDIOGRAM (ECG) CLEARANCE

Parents/Guardians: An ECG screen (also referred to as an EKG) can help identify young athletes who are at risk for sudden cardiac death, a condition where death results from an abrupt loss of heart function. An ECG screening may assist in diagnosing several different heart conditions that may contribute to sudden cardiac death. In accordance with School Board Policy JJ: Extracurricular Activities, The School Board of Orange County, Florida is requiring each student athlete wishing to participate in high school athletics to have 1 electrocardiogram (ECG) screening prior to participating in his or her first athletic sport in high school. **The initial ECG may be completed by any licensed physician, including a primary care physician, pediatrician, licensed physician assistant, or certified advanced registered nurse practitioner. If the ECG comes back ABNORMAL, the student may only participate after being cleared by a cardiologist or a pediatric cardiologist.**

STUDENT INFORMATION: (Please Print)

Student Name: _____ **Student ID#:** _____ **DOB:** _____

_____ _____ _____

Parent/Legal Guardian Signature **Parent/Legal Guardian Name Printed** **Date**

☐ **If your ECG was completed by Who We Play For, you can STOP here.** Submit the email you received from the organization to Athletic Clearance, along with the top portion of this form completed. Both the email and this form with the top completed must be submitted.

ECG's performed by a PCP, Urgent Care Center, or Walk-in Clinic must complete the form below

PHYSICIAN INSTRUCTIONS: This form is to be completed by an appropriate health care provider (AHCP) trained in the latest ECG interpretation guidelines. It is recommended to interpret ECG readings based on the International Criteria (https://uwsportscardiology.org/). After completing and interpreting the ECG, select the appropriate box below. If the ECG is interpreted as NORMAL, complete the Normal Electrocardiogram Clearance. If the initial ECG is interpreted as ABNORMAL, the student must be referred to a cardiologist. Only a cardiologist can clear a student with an ABNORMAL ECG interpretation.

NORMAL Electrocardiogram Clearance:

(To be completed in full by a licensed physician, PA or ARNP)

I hereby certify that an ECG was performed by myself or an individual under my direct supervision with the following conclusion:

☐ Low Risk/Cleared for Participation

_____ _____ _____

Physician/PA/ARNP Signature Name of Physician/PA/ARNP (print) Date

Stamp of Physician Office: _____ Phone: _____

Address: _____ City: _____ Zip: _____

☐ An ABNORMAL ECG was found and student has been referred to cardiology. Physician name: _____ Date: _____

ABNORMAL Electrocardiogram Clearance:

(To be completed in full by a cardiologist or pediatric cardiologist)

An abnormal ECG screening was found and the student was subsequently evaluated by a cardiologist or pediatric cardiologist.

☐ I hereby certify that the student above has had a cardiac evaluation and is cleared for athletic participation from a cardiac perspective.

_____ _____ _____

Cardiologist/Pediatric Cardiologist Signature Cardiologist/Pediatric Cardiologist Name (Print) Date

Stamp of Cardiology Office: _____ Phone: _____

Address: _____ City: _____ Zip: _____

See Section 1006.20(2)(c), Florida Statutes.