

TC Athletes / Band Members

The following needs to be completed annually for participation in
practice, workouts & games.

1. Register through FHSAA (Florida High School Athletic Association) to participate in Athletics:

www.athleticclearance.com – need to register or re-register for the 2025-2026 school year.

Online Athletic Clearance

1. Visit **AthleticClearance.com**
 2. Select Florida
 3. **Return Users**
 - Enter login information and click “Sign In”
 4. **First Time Users:**
 - Create an Account. PARENTS/GUARDIANS will register with a valid email username and password.
 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. 2025 - This would be the 2025-2026 School Year.
 - School at which the student attends and will compete at
 - Sport/s (We recommend that if the student is participating in multiple sports, that those sports are added all at once)
 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 please print the form, sign the form, and upload the form.**
 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.
- 2. Completed physical on FHSAA EL2 Form – form is on TC Website; you can upload the physical form on athleticclearance.com or turn the form into the Athletic Office. Physical is valid for 365 days from the evaluation**
- 3. Instructions for the Impact Baseline Test (only needs to be done once during high school not every year) can only be completed on a lap top or desk top:**
1. www.impacttestonline.com/testing
 2. customer ID Code: 270eca3197
 3. Click on Launch Baseline Test
 4. Click on English
 5. Follow the prompts
 6. Upload the Impact Baseline Test Certificate to athleticclearance.com

4. Instructions for the required NFHS courses
Heat Illness Prevention, Concussion for Students and Sudden Cardiac Arrest (Athletes Only)

Course Ordering

Step 1: Go to www.nfhslearn.com.

Step 2: “**Sign In**” to your account using the email address and password you provided at time of registering for a nfhslearn account.

OR

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

Step 3: Click “**Courses**” and select “Concussion for Students”, “Heat Illness Prevention and “Sudden Cardiac Arrest”, all 3 courses need to be completed.

Step 4: Select your state and click “**Order Course.**”

Step 5: Select “**Myself**” if the course will be completed by you.

Step 6: Click “**Continue**” and follow the on-screen prompts to finish the checkout process. (Note: There is no fee for this course.)

Beginning a Course

Step 1: Go to www.nfhslearn.com.

Step 2: “**Sign In**” to your account using the email address and password you provided at time of registering for a nfhslearn account.

Step 3: From your “**Dashboard,**” click “**My Courses**” and select the “**Active**” tab.

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

*Your course will launch on the same page of the web browser.

Click “Back to Dashboard**” when ready to exit course.

Please upload each certificate to athletic clearance.

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. If you should experience any issues while taking the course, please contact the NFHS Help Desk at 1-317-565-2023.

5. A team participation fee will be billed through FACTS.

6. ECG Clearance for Athletic Participation form needs to be turned into the Athletic Office before participation.



Electrocardiogram Clearance for Athletic Participation

An Electrocardiogram (ECG) 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 heart death. Trinity Catholic High School 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 initial ECG comes back ABNORMAL, the student may only participate after being cleared by a cardiologist or a pediatric cardiologist and execution of an assumption of the risk and hold harmless agreement.

Student Name (PRINT): _____ DOB (Date of Birth) _____

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

If the ECG is completed by Who We Play For, Orlando Health, Advent Health or Neumors
Stop here and submit this form with the top portion completed along with the email received from the organization.

If the ECG is completed by a licensed physician, PA, ARNP, Urgent Care, or Walk-in-Clinic
An appropriate health care provider trained in the latest ECG interpretation guidelines must complete the below information. 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.

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

- A NORMAL Electrocardiogram was found and student is at Low Risk/Cleared for Participation
An ABNORMAL Electrocardiogram was found and the student is Not Cleared for Participation and is being referred to a cardiologist for further review. Only a cardiologist can clear a student with an ABNORMAL ECG interpretation

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

Phone: _____ Address: _____ City: _____ Zip: _____

*Stamp of Physician Office must be included _____

An ABNORMAL Electrocardiogram screening was found and the student must be evaluated by a cardiologist or pediatric cardiologist to be cleared for participation.

- 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 (print) _____ Date _____

Phone: _____ Address: _____ City: _____ Zip: _____

*Stamp of Cardiologist Office must be included _____



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 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.				<i>(continued)</i>			
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 of exam.

EL2

Revised 2/25

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: ___ / ___ / ___



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 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 (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.

- Medically eligible for all sports without restriction
Medically eligible for all sports without restriction after clearance by medical specialist for:
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.

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)*