



ONLINE ATHLETIC CLEARANCE

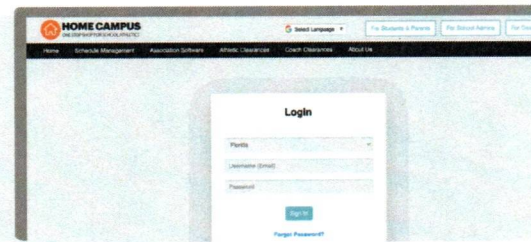
HOW TO COMPLETE YOUR CLEARANCE

Parent & Student Guide

homecampus.com

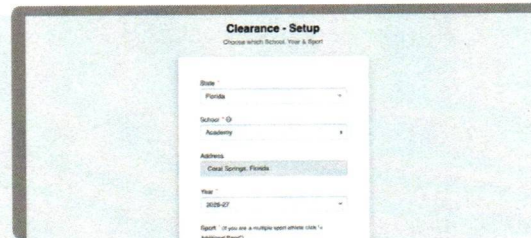
1 VISIT HOMECAMPUS.COM & LOG IN

- Go to HomeCampus.com, select Parents & Students and click Florida.
- New Users: Create an account with a valid parent/guardian email as your username and a password.
- Return Users: Log in with your email and password from the previous school year.



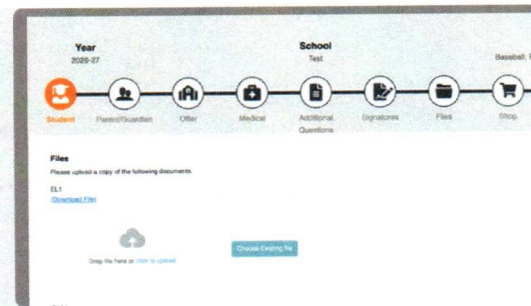
2 SELECT START CLEARANCE HERE

- Select State, Choose your School Year, School, and Sport(s).
- Participating in multiple sports? Add all sports at once using Add New Sport.
- Adding a sport to an existing clearance? Click + Sport and verify your application data.



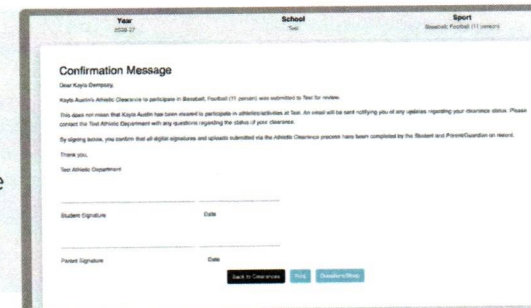
3 COMPLETE ALL REQUIRED SECTIONS

- Fill in Student Information, Parent/Guardian Information, Medical History, and Signature Forms.
- Return users: select your student/guardian from the dropdown — info will autofill.
- Signatures must be an EXACT match of what's on the Student & Parent/Guardian page.
- Upload required files (e.g. physical form). Use Choose Existing File to reuse a prior upload.



4 SUBMIT & WAIT FOR CONFIRMATION

- Click Submit Completed Application.
- You will see a Confirmation Message — your clearance is now submitted for school review.
- The student is NOT cleared yet — the school must review and approve before participation.
- You will receive an email notification once the school clears your student.



IMPORTANT: Reaching the Confirmation Message means your application has been submitted — but your student is **not yet cleared for participation**. The school's athletic department must review and approve. Watch for your email.

FREQUENTLY ASKED QUESTIONS

What is my username? Your username is the email address you registered with.

How do I register for multiple sports? Add all sports on the first step. If adding sports later, click + Sport and verify information.

Where do I find the physical form? Download it from the Medical History page or the Files Upload section.

Why haven't I been cleared yet? Your school reviews applications before clearing students. You will receive an email once cleared.

My sport isn't listed / I was denied. Contact your athletic department to activate a sport. For denials, check the email, update your clearance, then submit the application back to the school for review.



ELECTROCARDIOGRAM (ECG) SCREENING (Page 1 of 1)
SUBMIT THIS CLEARANCE FORM TO THE SCHOOL

EL1

Revised 2/26

ELECTROCARDIOGRAM (ECG) SCREENING 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: _____ Student ID: _____

Parent/Guardian: Review the FHSAA EL3 Consent and Release form for details on Sudden Cardiac Arrest. Per §1006.20, F.S. (Second Chance Act), effective July 1, 2026, all first-time high school participants in FHSAA athletics must have an Electrocardiogram (ECG) screening before participation. This applies to students with no cardiac symptoms. Students with cardiac symptoms should consult their healthcare provider. An ECG completed within two (2) years prior to July 1 of the participation year satisfies this requirement. If the ECG requires further evaluation, the student must be cleared by a licensed medical practitioner trained in the diagnosis, evaluation and management of ECGs before participating in FHSAA athletic competition, practice, tryouts, or workouts.

Please complete only ONE section (Section A or Section B, as applicable)

SECTION A: PARENT/GUARDIAN ATTESTATION (Select one and sign below)

- ☐ ECG completed by Who We Play For, a hospital in the state of Florida, or another healthcare organization and electronically signed by a licensed physician; attach normal result documentation from health record or the email received from provider.

Date of NORMAL ECG Result: ____/____/____ Organization Performing ECG: _____

OR

- ☐ Medical Exception - Attach FHSAA Form ME1
☐ Religious Objection - I object to an ECG for my child based on religious reasons allowed by law

Parent/Guardian Signature: _____ Printed Name: _____ Date: ____/____/____

SECTION B: LICENSED PRACTITIONER ATTESTATION - ECG Interpretation by healthcare provider

In accordance with §1006.20(2)(c), F.S., I certify I am a licensed practitioner (Ch. 458, 459, 460, 464.012, 464.0123 F.S. or equivalent) familiar with the "International Criteria for ECG interpretation in student-athletes". If the ECG is normal, complete the section below. If further evaluation is required, the student should be referred to a practitioner trained in the diagnosis, evaluation and management of ECGs.

- ☐ Normal ECG (no additional evaluation required)
☐ Normal variant ECG based on the International Criteria (no additional evaluation required)
☐ Further evaluation by a licensed medical professional is required, and an EL1/2S must be completed

Provider Signature: _____ Printed Name: _____ Date: ____/____/____

Credentials: _____ License #: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

If your ECG requires further evaluation and you need help accessing cardiology follow-up care, please visit www.whoweplayfor.org.

Please retain a copy for your records.



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 2/26

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

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.



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 2/26

Student's Full Name: _____ Date of Birth: ____ / ____ / ____ School: _____

BONE AND JOINT QUESTIONS		Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		
MEDICAL QUESTIONS		Yes	No
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?		
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
22	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
23	Have you ever become ill while exercising in the heat?		
24	Do you or does someone in your family have sickle cell trait or disease?		
25	Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (continued)		Yes	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that you gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

Explain "Yes" answers here:

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

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. Florida Statute 1006.20 requires a student candidate for an interscholastic athletic team to successfully complete a preparticipation physical evaluation as the first step of injury prevention. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine physical evaluation required by Florida Statute 1006.20, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test. The FHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____ (printed) Student-Athlete Signature: _____ Date: ____ / ____ / ____

Parent/Guardian Name: _____ (printed) Parent/Guardian Signature: _____ Date: ____ / ____ / ____

Parent/Guardian Name: _____ (printed) Parent/Guardian Signature: _____ Date: ____ / ____ / ____



PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)
This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date of exam.

EL2

Revised 2/26

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 2/26

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: _____

(If this option is checked, additional medical follow-up and clearance prior to sports participation is required. Use Form EL1/2S 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, or a practitioner who holds an active equivalent licensure issued by the state in which the medical evaluation was performed 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.



THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Department of Curriculum and Instruction
75 N. Pace Blvd.
Pensacola, FL 32505

ANNUAL CONSENT TO STUDENT DRUG SCREENING

SCHOOL YEAR 2026 - 2027

I understand that submission to testing for the presence of drugs is a condition of parking on campus and/or participation in interscholastic athletics and/or extra/co-curricular activities. I further understand if I refuse to take the test, or if the test establishes a violation of the random drug test policy, I will forfeit my privilege of parking on campus and be removed from participation in athletics and/or extra/co-curricular activities until satisfactorily complying with the Random Drug Testing Policy.

By signing and dating this form, I consent to random drug screening and the sanctions thereof throughout the school year. The selection for the random screenings will be performed on a weekly basis with the selected students being notified on the day they are to report for urinalysis.

By signing and dating this form, I understand that the cost of the initial random screening will be paid for by the school district. Furthermore, I understand that the cost of all follow-up drug testing will be the responsibility of the student if the follow-up test results in a positive outcome. If the results are determined to be negative, the district will be responsible for reimbursement. I also understand that the cost for the assessment and rehabilitation program and any additional testing in the event of a violation of the random drug testing policy is also the responsibility of the student.

I, parent or legal guardian, hereby consent to the administration of the drug screening and to the conditions listed in this consent. By signing and dating this form, I attest that I have read and understand the attached Random Drug Testing Policy.

Student's Name: _____ Student ID: _____

Date : _____ Signature: _____

Parent/Guardian's Name: _____

Date : _____ Signature: _____

State of Florida, County of _____

Sworn to and subscribed before me this _____ day of _____, 20____,
by _____

who is personally known to me ____ or who had produced _____ identification.

(Signature of Notary Public)

(Print Name of Notary Public)

(Notary Seal)

If your child is selected for random drug screening, an attempt will be made to notify you either by phone or letter of both selection for screening and the subsequent result. The best number to reach you is _____. An alternate number is _____.