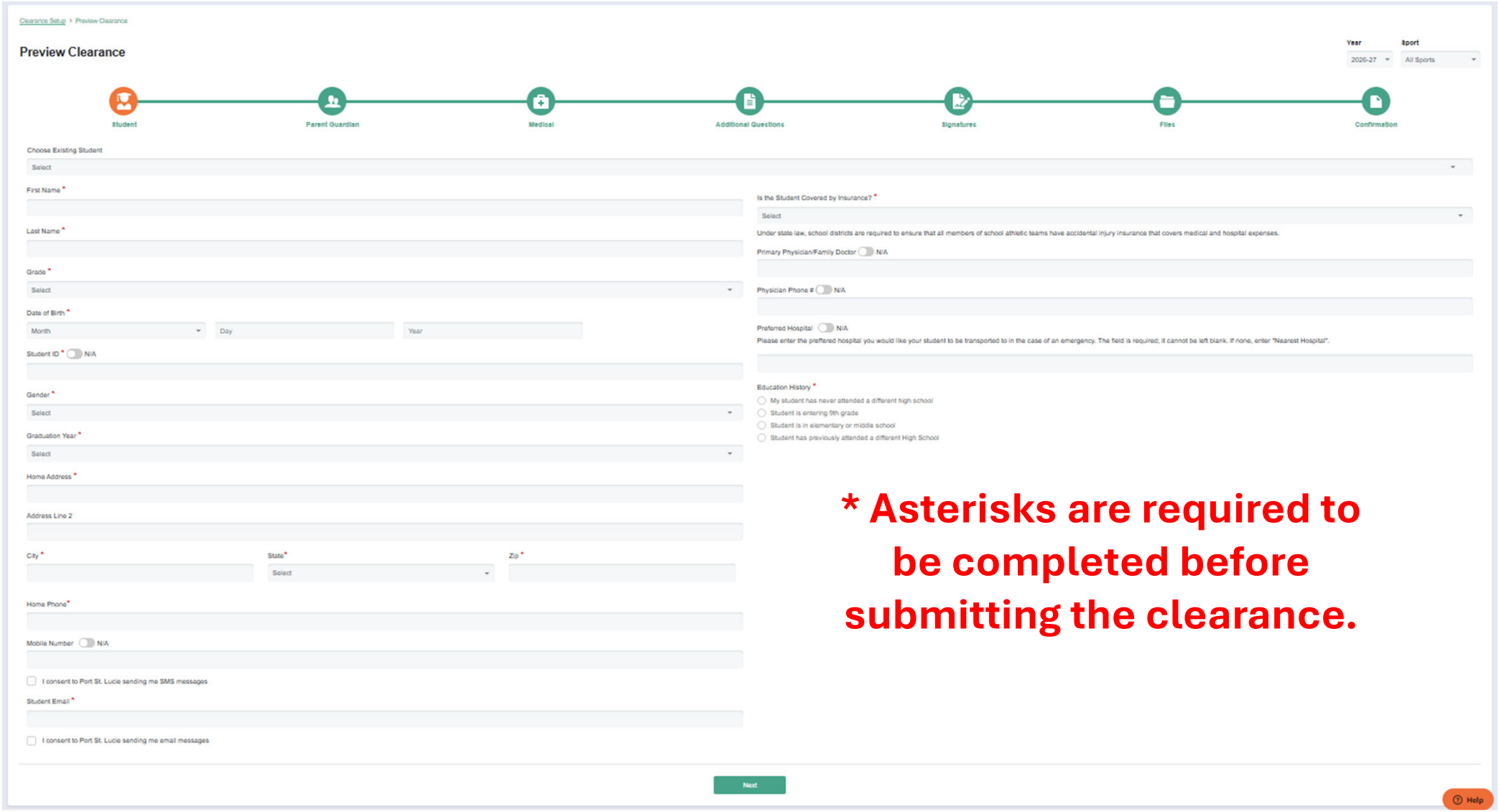
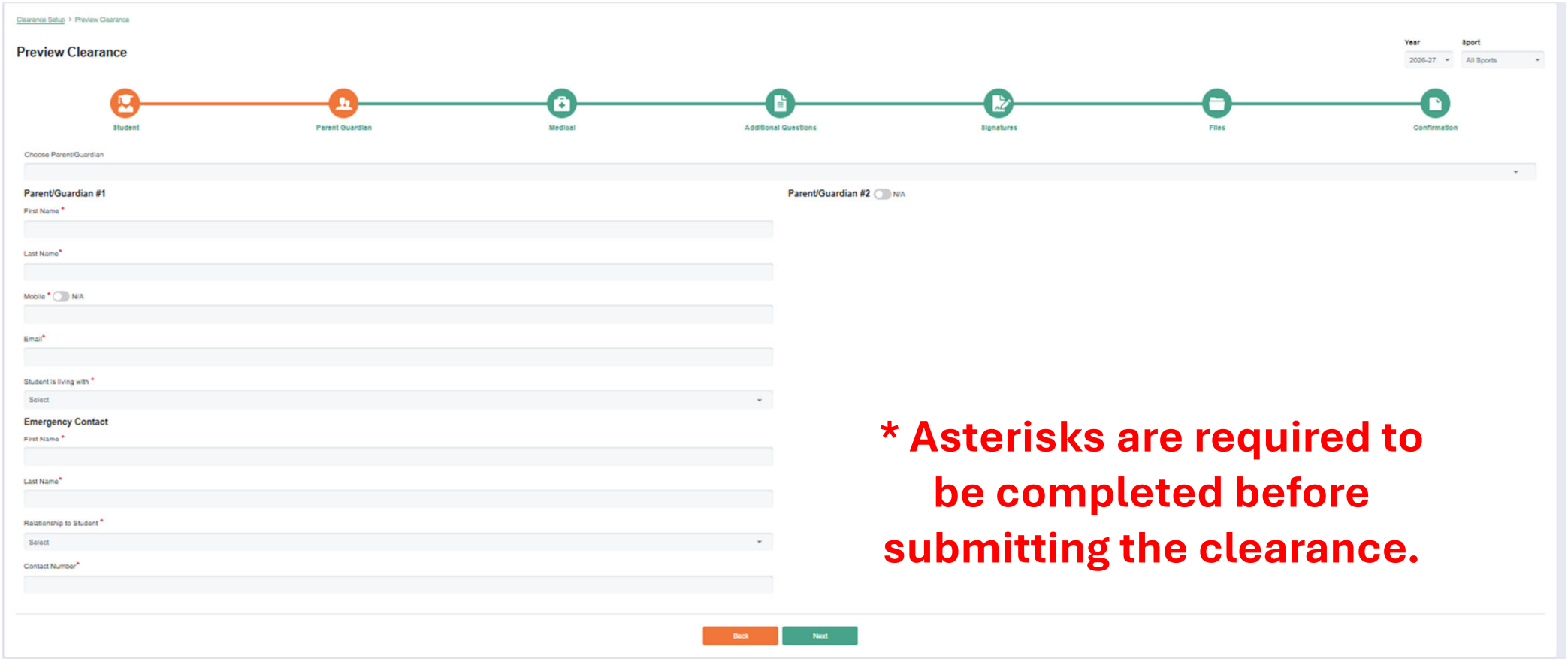
Athletic Clearance 2026-2027

Questions? Contact Harold.Barnwell@stlucieschools.org

FLORIDA
HIGH SCHOOL ATHLETIC ASSOCIATION


Clearance Setup › Preview Clearance
Preview Clearance
Year
2026-27
Sport
All Sports
Student
Parent Guardian
Medical
Additional Questions
Signatures
Files
Confirmation
Choose Existing Student
Select
First Name *
Last Name *
Grade *
Select
Date of Birth *
Month
Day
Year
Student ID * N/A
Gender *
Select
Graduation Year *
Select
Home Address *
Address Line 2
City *
State *
Select
Zip *
Home Phone *
Mobile Number N/A
I consent to Port St. Lucie sending me SMS messages
Student Email *
I consent to Port St. Lucie sending me email messages
Is the Student Covered by Insurance? *
Select
Under state law, school districts are required to ensure that all members of school athletic teams have accidental injury insurance that covers medical and hospital expenses.
Primary Physician/Family Doctor N/A
Physician Phone # N/A
Preferred Hospital N/A
Please enter the preffered hospital you would like your student to be transported to in the case of an emergency. The field is required; it cannot be left blank. If none, enter "Nearest Hospital".
Education History *
My student has never attended a different high school
Student is entering 9th grade
Student is in elementary or middle school
Student has previously attended a different High School
* Asterisks are required to be completed before submitting the clearance.
Next
Help


Clearance Setup › Preview Clearance
Preview Clearance
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Additional Questions
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Confirmation
Choose Parent/Guardian
Parent/Guardian #1
First Name *
Last Name*
Mobile * N/A
Email*
Student is living with *
Select
Emergency Contact
First Name *
Last Name*
Relationship to Student *
Select
Contact Number*
Parent/Guardian #2 N/A
* Asterisks are required to be completed before submitting the clearance.
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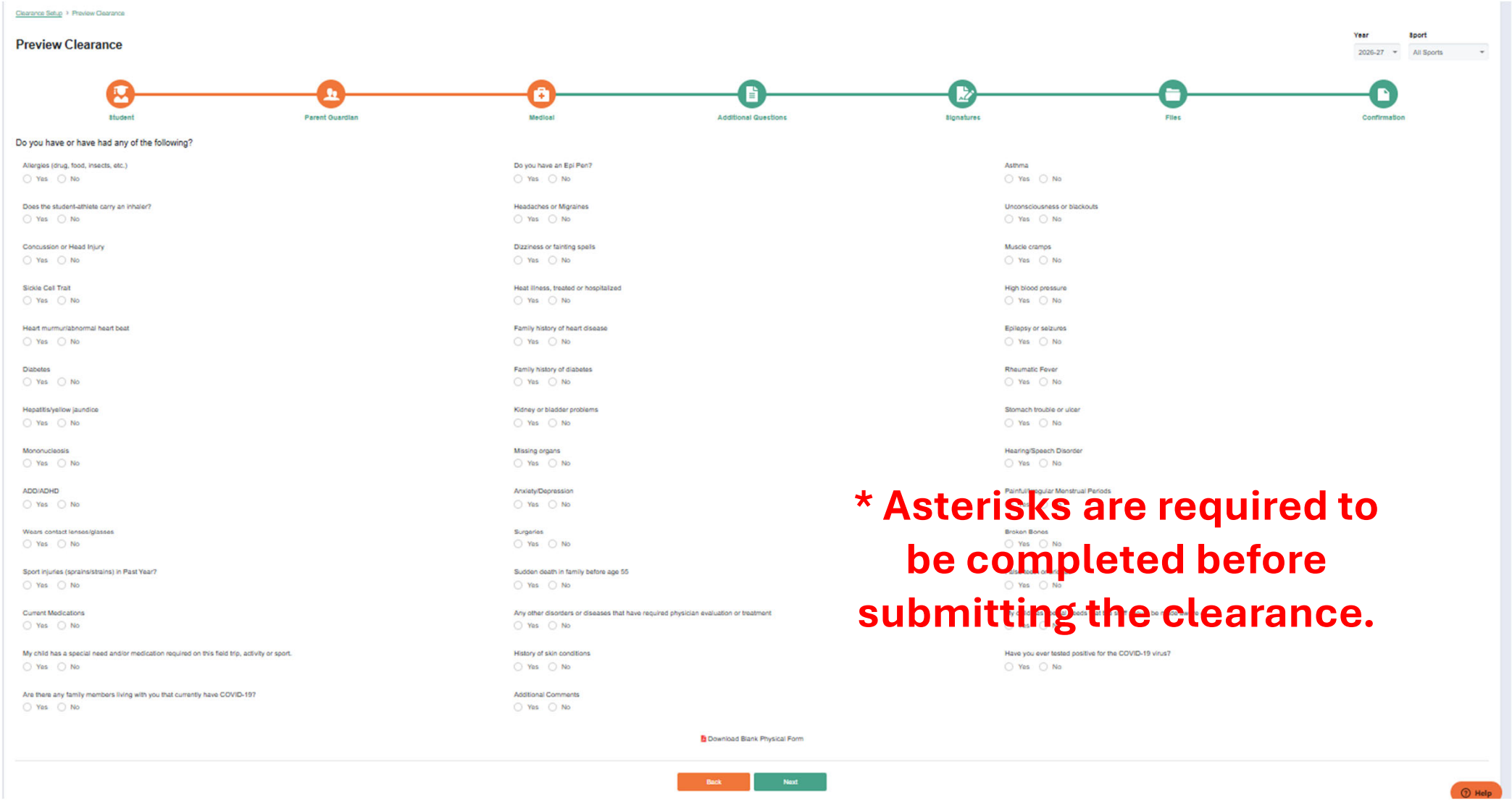
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Do you have or have had any of the following?
Allergies (drug, food, insects, etc.)
Yes No
Does the student-athlete carry an inhaler?
Yes No
Concussion or Head Injury
Yes No
Sickle Cell Trait
Yes No
Heart murmur/abnormal heart beat
Yes No
Diabetes
Yes No
Hepatitis/yellow jaundice
Yes No
Mononucleosis
Yes No
ADD/ADHD
Yes No
Wears contact lenses/glasses
Yes No
Sport injuries (sprains/strains) in Past Year?
Yes No
Current Medications
Yes No
My child has a special need and/or medication required on this field trip, activity or sport.
Yes No
Are there any family members living with you that currently have COVID-19?
Yes No
Do you have an Epi Pen?
Yes No
Headaches or Migraines
Yes No
Dizziness or fainting spells
Yes No
Heat illness, treated or hospitalized
Yes No
Family history of heart disease
Yes No
Family history of diabetes
Yes No
Kidney or bladder problems
Yes No
Missing organs
Yes No
Anxiety/Depression
Yes No
Surgeries
Yes No
Sudden death in family before age 55
Yes No
Any other disorders or diseases that have required physician evaluation or treatment
Yes No
History of skin conditions
Yes No
Additional Comments
Yes No
Asthma
Yes No
Unconsciousness or blackouts
Yes No
Muscle cramps
Yes No
High blood pressure
Yes No
Epilepsy or seizures
Yes No
Rheumatic Fever
Yes No
Stomach trouble or ulcer
Yes No
Hearing/Speech Disorder
Yes No
Painful/Irregular Menstrual Periods
Broken Bones
Yes No
Yes No
Have you ever tested positive for the COVID-19 virus?
Yes No
* Asterisks are required to be completed before submitting the clearance.
Download Blank Physical Form
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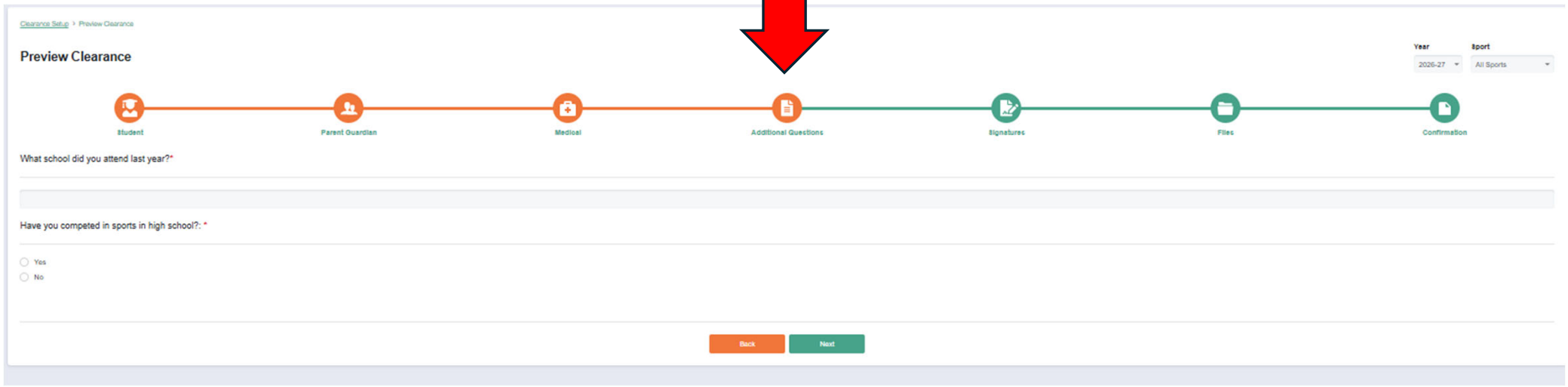
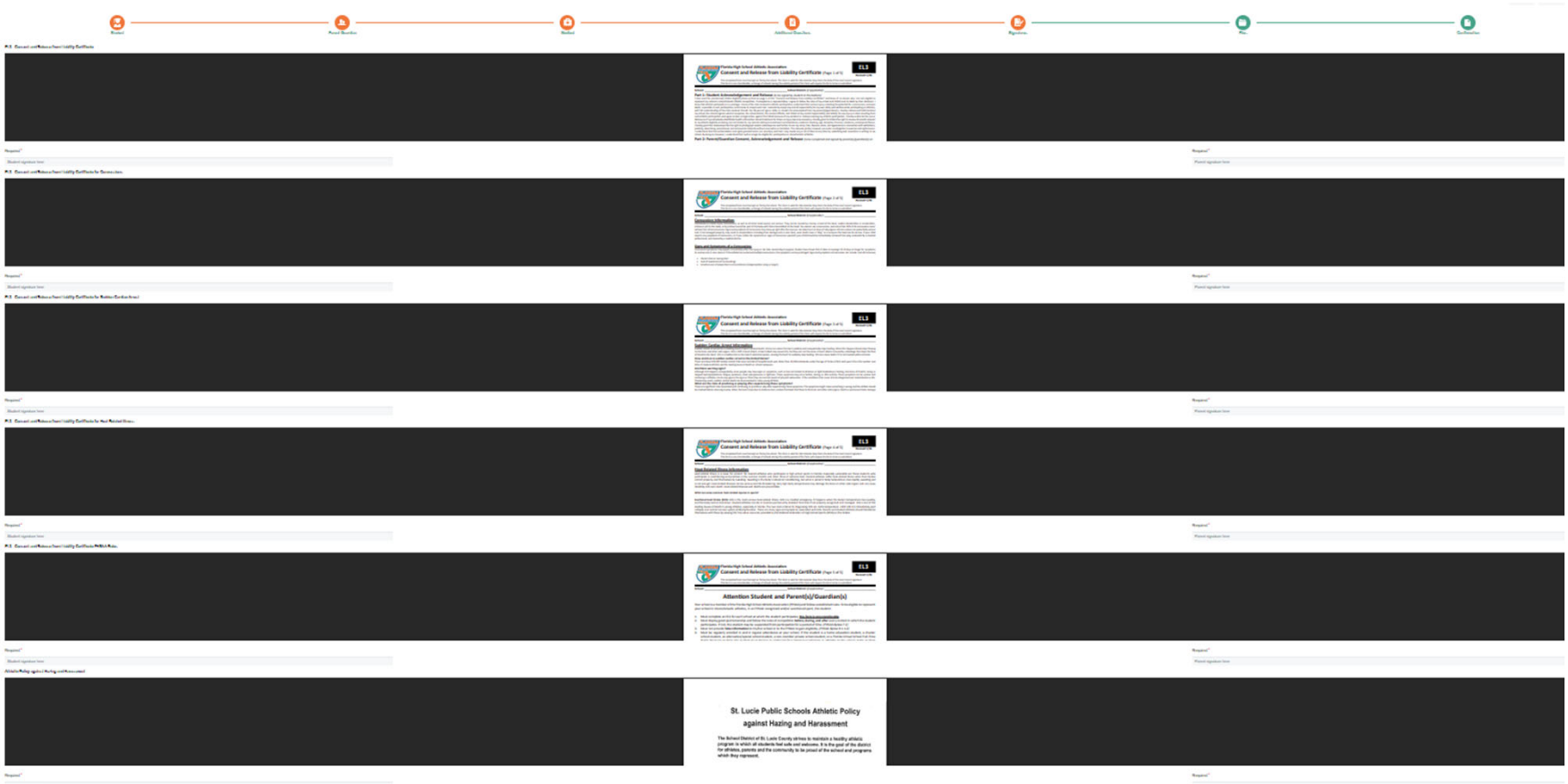
Monitor Clearance Progress



Download all forms, complete forms, submit forms on following page.



Ensure your healthcare provider checks this box!

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.

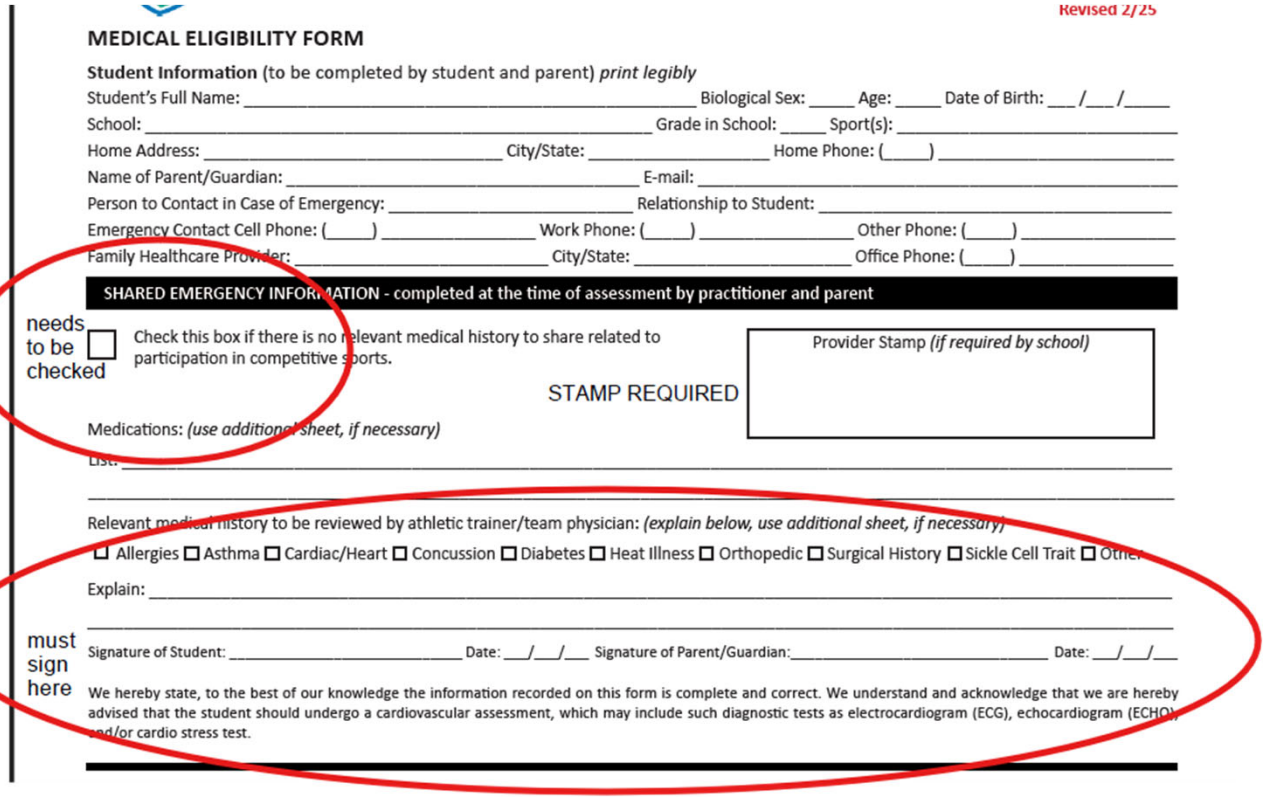
• Do you feel stressed out or under a lot of pressure?	• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Do you drink alcohol or use any other drugs?	• Have you ever taken anabolic 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 those 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		

Ensure the box is checked, Provider Stamped, and Student and Parent Signatures



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

needs to be checked

☐ Check this box if there is no relevant medical history to share related to participation in competitive sports.

STAMP REQUIRED

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: _____

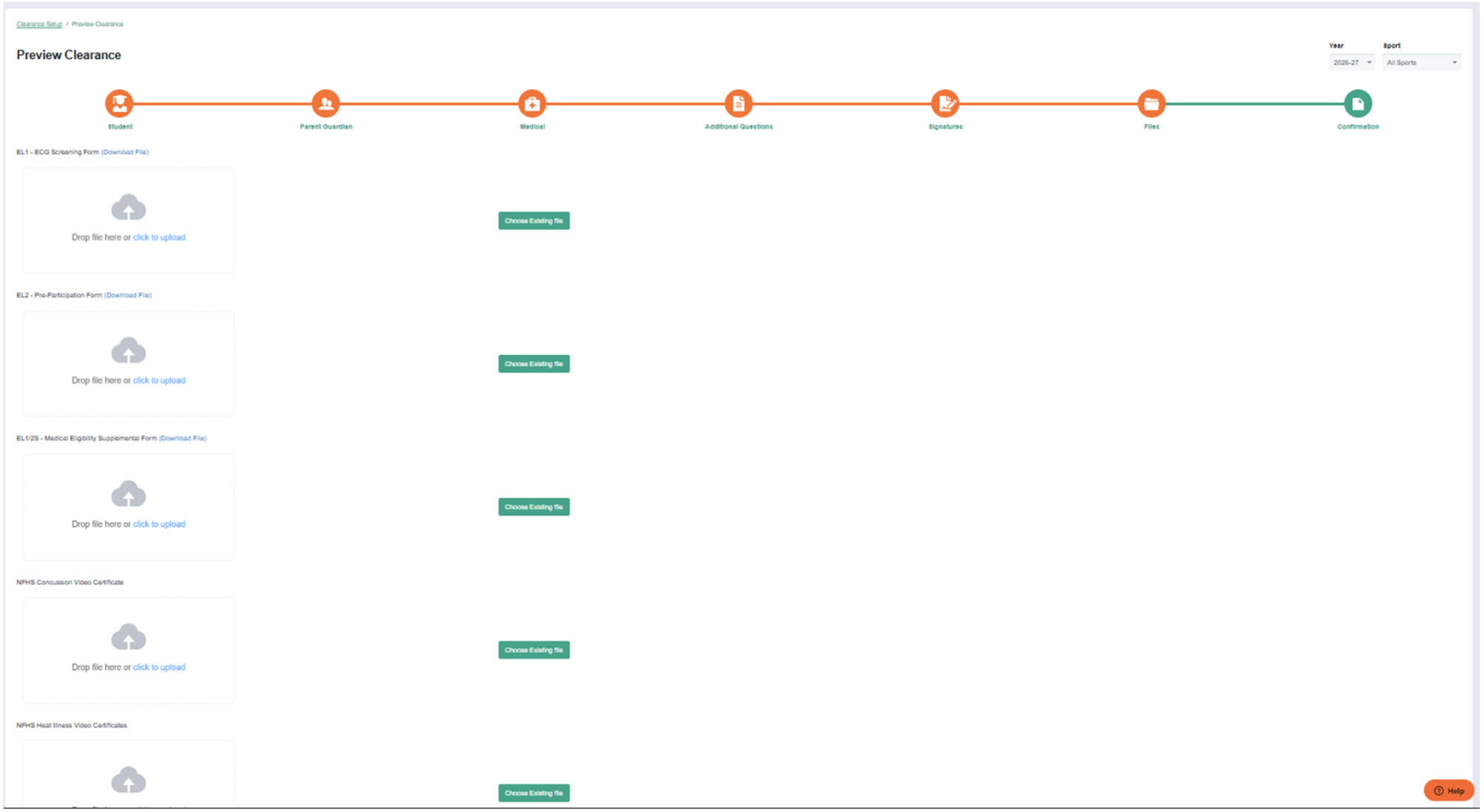
_____

must sign here

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.

Upload all completed forms.



Submit Final Clearance Paperwork
Ensure all parts of application are completed in full.