



RAIDERS ATHLETICS

WELCOME TO RAIDERS ATHLETICS! IN ORDER TO BECOME A RAIDER OR LADY RAIDER, PLEASE FOLLOW THE INSTRUCTIONS INCLUDED IN THE PACKET.

1. ALL STUDENT/ATHLETES MUST HAVE A COMPLETED PHYSICAL AND TURNED IN TO THE HEAD COACH OF THE PROGRAM, COACH MENDOZA (HEAD ATHLETIC TRAINER), OR COACH HANKERSON (ATHLETIC DIRECTOR).
2. ALL STUDENT/ATHLETES MUST REGISTER AT WWW.ATHLETICCLEARANCE.COM.
3. BOTH OF THESE TASKS MUST BE DONE BEFORE PARTICIPATION IS ALLOWED.

THANK YOU FOR BEING THE BEST PART OF RAIDERS ATHLETICS!

ONE NATION...RAIDER NATION!!!



Raiders Athletics Athletic Clearance Procedures

Thank you for participating in Raiders Athletics! Please follow the directions below to start the registration process to be eligible to participate.

All forms must be completed electronically. Please submit the Hard Copy Physical, Activity Form, and Home Campus Confirmation page to the Head Coach. Participation will not be allowed without Home Campus Clearance and Hard Copies.

1. Visit www.athleticclearance.com and choose Florida.
2. Watch the quick tutorial video.
3. **PARENTS:** First time users select **'Create An Account'**. Register with your name, a valid email username and password. You will be asked to type in a code to verify you are human, your account will *not* activate unless you do this.
4. Login using your email address that you registered with.
5. Select **'Start Clearance Here!'** to start the process.
6. Choose the current school year and School Rickards and Sport **' _____ '**
(Select only the sport you wish to participate in for right now) If a multi-sport athlete, click "Add Sport" to add the next sport.
7. Complete all required fields for Student Information. When selecting Educational History, you may be prompted to the GA4 form for any transfer students, this form must be printed and submitted to the Athletic Director, Coach Hankerson.
8. During the Medical History portion, you must upload a completed physical or download the physical form to be printed. Please upload the physical **AND** submit it to the Head Coach, Athletic Director, or Coach Mendoza.
9. Complete all required fields for Medical History, and Signature Forms pages.
10. Parents, if you **do not** want to receive emails from NCSA (college recruiting partner), you will need to check the box NO THANKS on the 3rd page of the registration.
11. Next, you will have the *option* to donate to Rickards Athletics.
12. Once you have reached the Confirmation Message you have completed the online process.
13. If you would like to register for additional sports you may check off those sports below the Confirmation Message. Electronic signatures will be applied to the additional sports.

All of this data will be electronically filed with Raiders Athletic Department for review. When the student has been cleared for participation, an email notification will be sent.

In addition to the online eligibility clearance, student athletes must have a minimum 2.0 state cumulative GPA as well as a current physical on file in order to be eligible for participation.

Email hankerson@leonschools.net or mendozak@leonschools.net with questions or concerns.



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 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 |
|--|--|-----|----|
| Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer. | | | |
| 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 | | Yes | No |
|---|---|-----|----|
| <i>(continued)</i> | | | |
| 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 signed below.*

EL2
 Revised 3/23

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: ___/___/___

Modified from © 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.



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 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 #: _____



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 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)*



CONNECT WITH US ON

Social Media@

@RickardsAthletics



@RHSathletics1



@RickardsAthletics1



Coming Soon!

