Parent Playbook

2025-2026

1 Visit ATHLETICCLEARANCE.COM

- Choose Florida
- Log into Account

EVERYONE IS A NEW USER

New Users: Create an account. Please register with a valid Parent/Guardian email address as the username and generate a password.

2 Select START CLEARANCE

Select the Current School Year 25-26
(During Summer, select grade they will be going into.)

Select your Designated School: NICEVILLE

Select the sport you are trying out for (if you are playing multiple sports, add them.

3 Complete STUDENT INFORMATION

This will not be an option in year one! We are all new. Everyone will create an account year one. If you have previously used Athletic Clearance, select student parent/guardian from the dropdown menu. Most fields will auto fill with previous information. Be sure to update the fields that are not auto filled.

4 Complete All Required Documents.

a. Parent Permission form (must be notarized)
b. EL2 Physical form page 4 only (page 5 if necessary)
c. EL3 form. Signature will be electronically
d. Impact Concussion Baseline Test (have they taken test). Impact Baseline Test request form.
e. Proof of insurance (insurer's name and insurance number)

QUESTIONS? USE THE HELP ICON AT THE BOTTOM RIGHT SCREEN FOR ASSISTANCE!

ONLINE ATHLETIC CLEARANCE

5 Complete MEDICAL HISTORY.

6 Complete PARENT / GUARDIAN.

Enter a valid email address and check it. This is how we will communicate with you. (Wrong form, wrong page, missing signature or missing documents.

7 Complete Signatures

Place parent's name where it says parent's signature.

Place student's name where it says student's signature.

8 Click "Submit COMPLETED APPLICATION"

9 CONFIRMATION MESSAGE

Your clearance is ready for review by your school once you have reached the CONFIRMATION MESSAGE page.

THE STUDENT IS NOT CLEARED YET!

THE SCHOOL MUST REVIEW AND CLEAR THE STUDENT. AN EMAIL NOTIFICATION WILL BE SENT ONCE THE SCHOOL HAS REVIEWED AND CLEARED THE STUDENT FOR PARTICIPATION.

QUESTIONS? USE THE HELP ICON AT THE BOTTOM RIGHT SCREEN FOR ASSISTANCE!

OKALOOSA COUNTY SCHOOL DISTRICT

HIGH SCHOOL INTERSCHOLASTIC ATHLETICS PARENTAL PERMISSION, HOLD HARMLESS RELEASE, EMERGENCY MEDICAL AUTHORIZATION, AND AUTHORIZATION TO RELEASE INFORMATION

NOTICE TO THE MINOR CHILD'S NATURAL GUARDIAN:

READ THIS FORM COMPLETELY AND CAREFULLY. YOU ARE AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT EVEN IF OKALOOSA COUNTY SCHOOL DISTRICT, ITS SCHOOL BOARD, ITS OFFICERS, EMPLOYEES, AGENTS, OR ASSIGNS USES REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM, YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM OKALOOSA COUNTY SCHOOL DISTRICT, ITS SCHOOL BOARD, ITS OFFICERS, EMPLOYEES, AGENTS, OR ASSIGNS IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM AND OKALOOSA COUNTY SCHOOL DISTRICT, ITS SCHOOL BOARD, ITS OFFICERS, EMPLOYEES, AGENTS, OR ASSIGNS HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

**No student will be allowed to practice or participate in any organized interscholastic athletic activity until this document is signed, notarized, and returned to the school Athletic Department.*

Student Name: _____ Grade: _____ Female/Male

Address: _____ Home Phone: _____

City: _____ Zip: _____ Emergency Phone: _____

PURPOSE: To provide (i) the consent of parents and/or guardians for students to participate in interscholastic activities of the School District; (ii) to provide a hold harmless and release of liability; (iii) to authorize the provision of emergency medical treatment for that student who may become ill or injured during such activities; and (iv) authorizing the release of protected health information.

PLEASE COMPLETE ALL PARTS:

PART I – PARENTAL/GUARDIAN PERMISSION, ACKNOWLEDGEMENT, HOLD HARMLESS, AND RELEASE

A. I, _____ herby grant permission for _____ (Student Athlete) to participate at _____ School during the school year, and I know of, and acknowledge that my child/ward knows of the risks involved in interscholastic athletic participation, and understand that serious injury, and even death, is possible in such participation and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. With full understanding of the risks involved, I release and hold harmless my child's/ward's school, Okaloosa County School District, its School Board, its officers, employees, agents, or assigns (the "Released Parties"), of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against the Okaloosa County School District, its School Board, its officers, employees, agents, and assigns, because of any accident or mishap involving the athletic participation of my child/ward. As required by F.S. 1014.06(1), I specifically authorize healthcare services to be provided for my child/ward by a healthcare practitioner, as defined in F.S. 456.001, or someone under the direct supervision of a healthcare practitioner, should the need arise for such treatment while my child/ward is under the supervision of the school. I further hereby authorize the use, or the disclosure of my child's/ward's individually identifiable health information should treatment or illness or injury become necessary. I understand the Okaloosa County School District requires all students participating in interscholastic athletics be covered by a medical insurance policy providing minimum coverage of $25,000 for medical expenses. I hereby certify that _____ (Student Athlete) is covered by medical insurance providing at least $25,000 for medical expenses. The name of our medical insurance company is _____ which will cover this child in the event of an injury. I assume full responsibility and liability for any and all expenses connected with an injury and/or illness that is not paid by our insurance company or through Military benefits if this child is entitled to military privileges. I further certify I will notify the principal of the school this child is attending if there is any change in this insurance coverage, and I will purchase the student and/or football insurance offered at the school. (STUDENT AND/OR FOOTBALL INSURANCE MAY BE PURCHASED AT YOUR SCHOOL.)

B. I grant the Released Parties the right to photograph and/or videotape my child/ward and further to use said child's/ward's name, face, likeness, voice, and appearance in connection with exhibitions, publicity, advertising, and promotional and commercial materials without reservation or limitation. The Released Parties, however, are under no obligation to exercise said rights herein.

C. I also herby grant permission for my child/ward to be transported by private automobile and/or School District authorized transportation during the school year in which this Release is effective to and from all interscholastic sports events.

PART II – EMERGENCY MEDICAL AUTHORIZATION:

In the event reasonable attempts to contact me at _____ (phone number) have been unsuccessful, I give my consent for (1) the administration of any treatment deemed necessary by _____ (preferred physician) or _____(preferred dentist), or in the event the designated preferred practitioner is not available, by another physician or dentist and (2) the transfer and admission of the child to _____ (preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery. I hereby authorize any treating physicians, including athletic trainers and team volunteer doctors to provide information to school officials regarding my child's medical condition or injuries. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted. (Please list medications, allergies, etc. or write none.)

_____

**Medical providers may accept a photocopy of this signed authorization as if it were an original for all purposes.*

PART III – AUTHORIZATION/CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the athletic trainers, sports medicine staff and other health care personnel representing _____(Student Athlete) to release information regarding the Student Athlete's protected health information and related information regarding injury or illness during the student athlete's training for and participation in interscholastic sports at _____ School. This protected health information may concern the Student Athlete's medical status, medical conditions, injuries, prognosis, diagnosis, athlete's participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, hospitals and/or medical clinics and laboratories, Student Athlete's coaches, medical insurance coordinators, the school's Athletic Director and Principal, athletic and/or school administrators, chaplains and/or clergy members, and officials of Florida High School Athletic Conference. I also authorize the Student Athlete's coaches and other school staff to release protected health information to the athletic trainer, sports medicine staff and other health care personnel as identified above and to other health care professionals providing services to the Student Athlete. As the parent or guardian of the Student Athlete, I hereby confirm that I have signed this authorization/consent for the disclosure of the Student Athlete's protected health information voluntarily. I understand that my child's/ward's protected health information is protected by federal regulations under the Health Information Probability and Accountability Act (HIPAA) of the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment. I the parent/legal guardian understand that once protected health information is disclosed per authorization or consent, the information is subject to redisclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian understand that I may revoke this authorization/consent anytime by notifying in writing the school's athletic director, but if I do, it will not have any effect on the actions the Okaloosa County School District officials took in reliance on this authorization/consent prior to receiving the revocation. I understand that I may see and obtain a copy of all protected health information described on this form, for reasonable copy fee, if I ask for it. I further understand that I may request a copy of this form after I sign it. This authorization/consent expires one-year from the date signed.

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE AND RELEASE OF THE STUDENT ATHLETE'S PROTECTED HEALTH INFORMATION AS STATED.

****

Concussion & Heat Related Illness Information Release Form (EL3CH) must be signed along with this form PRIOR TO NOTARIZATION, and the terms and conditions of the EL3CH Form are considered incorporated into this authorization.

BY SIGNING BELOW, I VERIFY THAT I HAVE READ, REVIEWED, AND COMPLETED ALL THREE (3) PARTS OF THIS PERMISSION AND AUTHORIZATION FORM AND KNOW IT CONTAINS A HOLD HARMLESS RELEASE.

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

STATE OF FLORIDA – COUNTY OF OKALOOSA

The foregoing instrument was acknowledged before me by means of ___ physical presence or ___online notarization, this _____ day of _____, 20___, by _____.
Name of Person Acknowledged

_____
Signature of Notary Public – State of Florida

(Notary Seal)

_____
Name of Notary (Typed, Printed, or Stamped)

Personally Known ___ OR Produced Identification ___
Type of Identification Produced:

_____

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 #: _____

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: _____

(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.

MIS 5348
3/2015

OKALOOSA COUNTY SCHOOL DISTRICT
STUDENT INTERVENTION SERVICES
CONSENT FOR ImPACT NEUROCOGNITIVE TESTING AND RELEASE OF INFORMATION
FOR ATHLETIC PARTICIPATION IN OKALOOSA COUNTY

PLEASE CHECK AND COMPLETE SECTION "A" OR "B" AND SIGN AT THE BOTTOM

_____**Section A**

I give my permission for (name of child)_____
(Date of Birth)_____to take the ImPACT Neurocognitive baseline concussion test administered by the Okaloosa School District system through any of its designated employees and/or approved volunteers. I give permission for my child to provide all the information requested necessary to complete the test. I understand that my child may need to be tested more than once, depending on the validity of the testing results.

I also understand that the test results of the ImPACT Neurocognitive test may be released to my child's guidance counselor and teachers, including Principals, Athletic Coaches and trainers, and nurses for the purpose of providing temporary academic and athletic modifications if necessary for concussion management. I also consent to the release of the ImPACT testing results to any Medical Physician, who in the treatment of my concussed child, submits a request for release of medical records complaint to State and Federal guidelines.

I understand that I may revoke this consent forNeurocognitive testing at any time; however, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality.

_____**Section B**

I **do not** give my permission for (name of child)_____
(Date of Birth)_____ to take the ImPACT Neurocognitive baseline concussion test administered by the Okaloosa School District system.

Parent(Guardian) Signature_____ Date_____

Student Signature_____ Date_____