

**Athletic Training Program:**  
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## Physical Online Submission Instructions

### **Includes All Sports, JROTC, Competitive Dance Teams, Marching Band and Guard**

- Please be mindful of the OCPS 48 hour rule. It takes up to 2 school days to process paperwork. During summer, clearances may take 2-3 weeks.
- Same day clearance is not possible
- Online clearance must be done at the beginning of each school year even if physical is still valid. Consent forms for each school year need to be digitally signed and medical information updated.
- See [WPHS Athletic Website](#) for more Physical information and ECG locations.

### **You will need these forms completed first to finish the process below:**

- FHSAA EL2 Preparticipation Physical Exam [www.tinyurl.com/NewOCPSPhysical](http://www.tinyurl.com/NewOCPSPhysical)  
(Required Annually and good for 365 days)
- OCPS Cardiology Report : ECG Clearance [www.tinyurl.com/OCPSECGReport](http://www.tinyurl.com/OCPSECGReport)  
(Required once - before participation and valid throughout high school)  
This form **MUST** be filled out. Read instructions on form if you also need to upload the ECG results.
  - If your ECG was completed by Who We Play For, Orlando Health, Advent Health or Nemours, upload the email you received along with the top portion of the OCPS Cardiology Report Form. Other providers **MUST** fill out the OCPS Cardiology Report Form.

**ALWAYS KEEP HARD COPIES OF FORMS – ECG IS GOOD FOR 4 YEARS BUT NEEDS TO BE UPLOADED EACH YEAR WITH PHYSICAL.**

## Instructions for Submitting Physical Online

1. Go to [www.AthleticClearance.com](http://www.AthleticClearance.com) and select FL.
  - a. **First Time Users:**
    - i. **Create an Account.** PARENTS/GUARDIANS will register with a valid parent/guardian email username and password.
    - ii. A Parent or Guardian email **MUST BE USED.**
  - b. **Return Users:**
    - i. Enter login information and click "Sign In"
    - ii. Make sure to use account previously used or prior information will not transfer (such as ECG Date requiring you to upload the new ECG form)
2. **Sign In** using your parent/guardian email address that was used to register.
3. Select "**Start Clearance Here or Add New Clearance**" to start the process.
4. Choose:
  - a. School Year: 2024-2025
  - b. School: Winter Park High School
  - c. Sport/s: Select ALL sports your student may choose to participate. (harder to add later)
5. Complete all required fields:
  - a. Student Information

- b. Parent/Guardian Information
  - c. Medical History
  - d. Signature Forms (Names must be exact match to previous information; case sensitive)
  - e. ONLY Upload Required Forms (see below)
    - i. Physical on **FHSAA EL2 – NEW FORM REVISED 4/24**
      1. Upload Only Page 4 (and supplement, pg.5, if you were referred for further clearance)
      2. Make sure all information is complete: **HANDWRITTEN parent/student signatures**, doctor writes date of the physical, **Doctor signature and must be stamped to show physician office/address**
    - ii. OCPS Cardiology Report: ECG Clearance
      1. This form **MUST** be filled out. Read instructions on form if you also need to upload the ECG results.
      2. If your ECG was completed by Who We Play For, Orlando Health, Advent Health or Nemours, upload the email you received along with the top portion of the OCPS Cardiology Report Form. Other providers **MUST** fill out the OCPS Cardiology Report Form. For any ECG that is not normal the physician box needs to be filled out on this form.
  - f. Click “Submit Your Completed Registration”
6. Once you reach the **Confirmation Message** you have completed the online registration process.
7. **The student is not Cleared yet!** This data will be electronically filed with the WPHS Athletic Training department for review. When the student has been cleared for participation, an email notification will be sent to the registered email from Athletic Clearance. Please be mindful of the OCPS 48 hour rule. It takes up to 2 school days to process paperwork. Sometimes longer at the beginning of each season.

**Questions?** Use the yellow Help option on the bottom right of the screen and submit a ticket.

### **Online Athletic Clearance FAQ**

- **Username:** Your username is the email address used during registration.
- **Existing Clearance:** If you have clearance already, think of it as a folder for that year. You can still access it to upload files.
- **Registering for Multiple Sports:** Add all sports during initial registration. For additional sports, start a new clearance.
- **Denial of Clearance:** If denied, check your email for reasons and update accordingly. Contact the Athletic Training Department if not reviewed after 2 school days.
- **Status of Clearance:** Your school will review and change your clearance status. You'll receive an email once cleared.

Remember to keep hard copies of forms, and note that ECG is valid for 4 years but needs to be uploaded each year with the physical. You can download the physical form from the Medical History page or obtain copies from the WPHS 9th Grade Center and Main Campus front office. Your uploaded files are stored for future access. For further assistance, use the yellow Help option on the bottom right of the screen to submit a ticket.



## 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 4/24**

### 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 signed below.

**EL2**

Revised 4/24

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 signed below.

**EL2**

Revised 4/24

## 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 #: \_\_\_\_\_

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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 4/24

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: (\_\_\_\_) \_\_\_\_\_

The preparticipation physical evaluation must be administered by a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with the practitioner's regulatory board. (§1006.20(2)(c), F.S.)

- 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, 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 #: \_\_\_\_\_

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)
OCPS Requires Provider Stamp

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 4/24**

*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)*  
**OCPS Requires Provider Stamp**

# OCPS Cardiology Report: Electrocardiogram (ECG) Clearance

**Parents/Guardians:** An ECG screen (also referred to as an EKG) 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 cardiac death. In accordance with School Board Policy JJ titled Extracurricular Activities, The School Board of Orange County, Florida is requiring each student athlete wishing to participate in high school athletics to have 1 electrocardiogram (ECG) screening prior to participating in his/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 ECG comes back ABNORMAL, the student may only participate after being cleared by a cardiologist or a pediatric cardiologist.**

Student's Name: (Print): \_\_\_\_\_ Student ID #: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Legal Guardian Name Printed

Parent/Legal Guardian Signature

Date

If your ECG was completed by Who We Play For, Orlando Health, Advent Health, or Nemours, you can **STOP** here. *Submit the email you received from the organization to Athletic Clearance, along with the top portion of this form completed. Both the email and this form with the top completed must be submitted.*

## ECG's performed by a PCP, Urgent Care Center, or Walk-in Clinic must complete the form below

**PHYSICIAN INSTRUCTIONS:** This form is to be completed by an appropriate health care provider (AHCP) trained in the latest ECG interpretation guidelines. 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. If the ECG is interpreted as NORMAL, complete the Normal Electrocardiogram Clearance. If the initial ECG is interpreted as ABNORMAL, the student must be referred to a cardiologist. Only a cardiologist can clear a student with an ABNORMAL ECG interpretation.

### NORMAL Electrocardiogram Clearance:

**(To be completed in full by a licensed physician, PA or ARNP)**

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

Low Risk/Cleared for Participation

\_\_\_\_\_  
Name of Physician/PA/ARNP (print)

\_\_\_\_\_  
Signature of Physician/PA/ARNP

\_\_\_\_\_  
Date

Stamp of Physician Office: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

An ABNORMAL ECG was found and student has been referred to cardiology. Physician name: \_\_\_\_\_ Date: \_\_\_\_\_

### ABNORMAL Electrocardiogram Clearance:

**(To be completed in full by a cardiologist or pediatric cardiologist)**

An abnormal ECG screening was found and the student was subsequently evaluated by a cardiologist or pediatric cardiologist.

I hereby certify that the student above has had a cardiac evaluation and is cleared for athletic participation from a cardiac perspective.

\_\_\_\_\_  
Name of Cardiologist/Pediatric Cardiologist (print)

\_\_\_\_\_  
Signature of Cardiologist/Pediatric Cardiologist

\_\_\_\_\_  
Date

Stamp of Cardiology Office: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_