MIAMI-DADE COUNTY PUBLIC SCHOOLS

ELECTROCARDIOGRAM (ECG/EKG) CLEARANCE

(Pursuant to School Board Policy 2431: Interscholastic Activities and Athletics)

NOTICE TO PARENTS/GUARDIANS

Participation in interscholastic athletics requires medical clearance to safeguard the health and safety of all student athletes. An electrocardiogram (ECG/EKG) is a diagnostic screening tool that may assist in the identification of cardiac abnormalities associated with the risk of **sudden cardiac arrest (SCA)** and other underlying cardiovascular conditions.

In accordance with Miami-Dade County Public Schools (M-DCPS) policy and consistent with Florida law, **each student-athlete must undergo a one-time ECG/EKG screening prior to participation in his or her first high school sport.**

- The initial ECG/EKG may be performed by a licensed physician, including a primary care physician, pediatrician, physician assistant (PA), or advanced registered nurse practitioner (ARNP). The ECG/EKG can be performed by a private provider. M-DCPS otherwise has ECG/EKG screenings available for all students through partnerships with local providers. Students may provide ECG/EKG screenings from 2023-2025 to satisfy this requirement.
- If the ECG/EKG is interpreted as ABNORMAL, the student shall not be permitted to participate until clearance is issued exclusively by a practitioner licensed under Chapter 458–460, Florida Statutes or 464.012, Florida Statutes; a practitioner registered under 464.0123, Florida Statutes; or a practitioner who holds an active equivalent licensure issued by the state in which the ECG/EKG is performed and is in good standing with the practitioner's regulatory board. The practitioner issuing the clearance must be trained in the diagnosis, evaluation, and management of ECG/EKGs. M-DCPS will assist parents in determining whether a practitioner is authorized to issue this medical clearance.

STUDENT INFORMATION (Please Print Clearly or Type)

- **Student Name:**
- **Student ID:**
- **Date of Birth (DOB):**

SUBMISSION INSTRUCTIONS

- If your ECG/EKG was completed by a partner organization (e.g., Jackson Health System, UHealth, Nicklaus Children's Hospital or Baptist Health), submit the email confirmation from the provider together with the completed STUDENT INFORMATION section above.
- If the ECG/EKG was performed by a **PCP, Urgent Care, or Walk-In Clinic**, the **health care provider must complete the PHYSICIAN CLEARANCE section below.**

PHYSICIAN CLEARANCE INSTRUCTIONS

This section must be completed by an **Appropriate Health Care Provider (AHCP)** trained in ECG interpretation standards. Interpretation shall be consistent with current International Criteria for ECG interpretation in athletes.

Select one (1) of the following determinations:

☐ **NORMAL / LOW-RISK – CLEARED FOR PARTICIPATION**

I hereby certify that an ECG/EKG was performed under my supervision and has been interpreted as **normal**, with no findings requiring restriction. The student is cleared for full athletic participation.

☐ **ABNORMAL – REFERRAL REQUIRED**

I hereby certify that an ECG/EKG was **performed** under my supervision and has been interpreted as **abnormal**. Student is **not cleared for participation** until further evaluation and written clearance is obtained from a practitioner licensed under Chapter 458–460, Florida Statutes or 464.012, Florida Statutes; a practitioner registered under 464.0123, Florida Statutes; or a practitioner who holds an active equivalent licensure issued by the state in which the ECG/EKG is performed and is in good standing with the practitioner's regulatory board.

I attest that I am duly licensed in the State of Florida to perform and/or interpret ECG/EKG studies within my professional scope of practice. The above conclusion represents my professional medical judgment. Provider ID No. _____

Provider Name (Print): _____

Signature:_____ Date: _____

Office Stamp (Required): _____

Address: _____ City: _____ Zip: _____ Phone: _____

MIAMI-DADE COUNTY PUBLIC SCHOOLS

ELECTROCARDIOGRAM (ECG/EKG) CLEARANCE

(Pursuant to School Board Policy 2431: Interscholastic Activities and Athletics)

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 Provider ID No. _____

_____ _____ _____

Physician/PA/ARNP Signature Name Physician/PA/ARNP (Typed/Print) Date

Stamp of Physician Office: _____ Phone: _____

Address: _____ City: _____ Zip: _____

☐ An **ABNORMAL ECG was found** and student has been referred to cardiology. to a practitioner licensed under Chapter 458–460, Florida Statutes or 464.012, Florida Statutes; a practitioner registered under 464.0123, Florida Statutes; or a practitioner who holds an active equivalent licensure issued by the state in which the ECG/EKG is performed and is in good standing with the practitioner's regulatory board.

Physican name: _____ Date: _____

PARENTAL ACKNOWLEDGMENT & CONSENT

By signing below, I acknowledge and consent to the following:

1. I understand that my child is required to undergo an ECG/EKG screening prior to participating in high school athletics in Miami-Dade County Public Schools.
2. I understand that an ECG/EKG is a screening tool and may not detect all cardiac conditions that could place my child at risk.
3. I understand that if the ECG/EKG is abnormal, my child will be referred for further evaluation and will not be permitted to participate until written clearance is provided by a practitioner licensed under Chapter 458–460, Florida Statutes or 464.012, Florida Statutes; a practitioner registered under 464.0123, Florida Statutes; or a practitioner who holds an active equivalent licensure issued by the state in which the ECG/EKG is performed and is in good standing with the practitioner's regulatory board.
4. I acknowledge that clearance for participation is based on the medical judgment of a licensed health care provider and not a guarantee of future health or absence of risk.
5. I consent to the use and disclosure of this medical information, consistent with federal and state law, to school officials as necessary for determining athletic eligibility.

Parent/Guardian Name (Print/Type): _____

Parent/Guardian Signature: _____

Date: _____

DISTRICT/SCHOOL VERIFICATION

This section must be completed by the school's Athletic Director, Principal, or authorized designee after receiving the clearance form and any required documentation.

☐ Documentation reviewed and verified.
☐ Student is cleared for athletic participation.
☐ Student is **not cleared** pending additional documentation.

Reviewed By (Print/Type): _____
Title (AD/Principal/Designee): _____

Signature: _____ Date: _____

IMPORTANT DISCLAIMER

- Clearance granted under this form does not substitute for a comprehensive pre-participation physical evaluation (PPE).
- Students with abnormal ECG/EKG findings must present additional clearance
- Falsification or alteration of this document may subject the student and/or provider to disciplinary or legal action under applicable law and School Board Policy.