



## PREPARTICIPATION PHYSICAL EVALUATION 2016-2017

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**HISTORY FORM – Please be advised that this paper form is no longer the OHSAA standard.**

(Note: This form is to be filled out by the student and parent prior to seeing the medical examiner.)

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Email) \_\_\_\_\_

**Medicines and Allergies:** Please list the prescription and over-the-counter medicines and supplements (herbal and nutritional-including energy drinks/ protein supplements) that you are currently takingDo you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.☐ Medicines☐ Pollens☐ Food☐ Stinging Insects**Explain "Yes" answers below. Circle questions you don't know the answers to.****GENERAL QUESTIONS**

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No

2. Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections Other: \_\_\_\_\_ Yes No

3. Have you ever spent the night in the hospital? Yes No

4. Have you ever had surgery? Yes No

**HEART HEALTH QUESTIONS ABOUT YOU**

5. Have you ever passed out or nearly passed out DURING or AFTER exercise? Yes No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Yes No

7. Does your heart ever race or skip beats (irregular beats) during exercise? Yes No

8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:

☐ High blood pressure☐ A heart murmur☐ High cholesterol☐ A heart infection☐ Kawasaki disease

Other: \_\_\_\_\_

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) Yes No

10. Do you get lightheaded or feel more short of breath than expected during exercise? Yes No

11. Have you ever had an unexplained seizure? Yes No

12. Do you get more tired or short of breath more quickly than your friends during exercise? Yes No

**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY**

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? Yes No

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? Yes No

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Yes No

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? Yes No

**BONE AND JOINT QUESTIONS**

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game? Yes No

18. Have you ever had any broken or fractured bones or dislocated joints? Yes No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? Yes No

20. Have you ever had a stress fracture? Yes No

21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) Yes No

**BONE AND JOINT QUESTIONS - CONTINUED**

22. Do you regularly use a brace, orthotics, or other assistive device? Yes No

23. Do you have a bone, muscle, or joint injury that bothers you? Yes No

24. Do any of your joints become painful, swollen, feel warm, or look red? Yes No

25. Do you have any history of juvenile arthritis or connective tissue disease? Yes No

**MEDICAL QUESTIONS**

26. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No

27. Have you ever used an inhaler or taken asthma medicine? Yes No

28. Is there anyone in your family who has asthma? Yes No

29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? Yes No

30. Do you have groin pain or a painful bulge or hernia in the groin area? Yes No

31. Have you had infectious mononucleosis (mono) within the past month? Yes No

32. Do you have any rashes, pressure sores, or other skin problems? Yes No

33. Have you had a herpes (cold sores) or MRSA (staph) skin infection? Yes No

34. Have you ever had a head injury or concussion? Yes No

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems? Yes No

36. Do you have a history of seizure disorder or epilepsy? Yes No

37. Do you have headaches with exercise? Yes No

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Yes No

39. Have you ever been unable to move your arms or legs after being hit or falling? Yes No

40. Have you ever become ill while exercising in the heat? Yes No

41. Do you get frequent muscle cramps when exercising? Yes No

42. Do you or someone in your family have sickle cell trait or disease? Yes No

43. Have you had any problems with your eyes or vision? Yes No

44. Have you had an eye injury? Yes No

45. Do you wear glasses or contact lenses? Yes No

46. Do you wear protective eyewear, such as goggles or a face shield? Yes No

47. Do you worry about your weight? Yes No

48. Are you trying to gain or lose weight? Has anyone recommended that you do? Yes No

49. Are you on a special diet or do you avoid certain types of foods? Yes No

50. Have you ever had an eating disorder? Yes No

51. Do you have any concerns that you would like to discuss with a doctor? Yes No

**FEMALES ONLY**

52. Have you ever had a menstrual period? Yes No

53. How old were you when you had your first menstrual period? Yes No

54. How many periods have you had in the last 12 months? Yes No

**Explain "yes" answers here**

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date: \_\_\_\_\_

The student has family insurance ☐ Yes ☐ No If yes, family insurance company name and policy number: \_\_\_\_\_





# Ohio High School Athletic Association



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## THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

**PLEASE COMPLETE ONLY IF YOUR STUDENT HAS SPECIAL NEEDS OR A DISABILITY.**

Date of Exam \_\_\_\_\_  
Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device or prosthetic?		
7. Do you use a special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you have any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date: \_\_\_\_\_



**PHYSICAL EXAMINATION FORM**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

**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?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - 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 supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet or use condoms?
  - Do you consume energy drinks?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		DATE OF EXAMINATION _____	
Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female
BP / ( / )	Pulse	Vision R 20/	L20/
		Corrected	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat Pupils equal Hearing			
Lymph nodes			
Heart Murmurs (auscultation standing, supine, +/- Valsalva) Location of the point of maximal impulse (PMI)			
Pulses Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional Duck walk, single leg hop			

\*Consider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.

\*Consider GU exam if in private setting. Having third part present is recommended.

\*Consider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

**CLEARANCE FORM**

Note: Authorization forms (pages 5 and 6) must be signed by both the parent/guardian and the student.

Name \_\_\_\_\_ Sex ☐ M ☐ F Age \_\_\_\_\_ Date of birth \_\_\_\_\_

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_

☐ Not Cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports \_\_\_\_\_

Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the pre-participation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. In the event that the examination is conducted en masse at the school, the school administrator shall retain a copy of the PPE. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician or medical examiner (print/type) \_\_\_\_\_ Date of Exam \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician/medical examiner \_\_\_\_\_, MD, DO, D.C., P.A. or A.N.P.

**EMERGENCY INFORMATION**

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

In case of Emergency, contact \_\_\_\_\_ Phone \_\_\_\_\_

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_



**THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS  
UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL**



**OHSAA AUTHORIZATION FORM 2016-2017**

I hereby authorize the release and disclosure of the personal health information of \_\_\_\_\_ ("Student"), as described below, to \_\_\_\_\_ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: \_\_\_\_\_

School Address: \_\_\_\_\_

This authorization will expire when the student is no longer enrolled as a student at the school.

**NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.**

Student's Signature \_\_\_\_\_

Birth date of Student, including year \_\_\_\_\_

Name of Student's personal representative, if applicable \_\_\_\_\_

I am the Student's (check one): ☐ Parent ☐ Legal Guardian (documentation must be provided)

Signature of Student's personal representative, if applicable \_\_\_\_\_

Date \_\_\_\_\_


**A copy of this signed form has been provided to the student or his/her personal representative**




**PREPARTICIPATION PHYSICAL EVALUATION 2016-2017**  
**2016-2017 Ohio High School Athletic Association Eligibility and Authorization Statement**

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This document is to be signed by the participant from an OHSAA member school and by the participant's parent.


 I have read, understand and acknowledge receipt of the **OHSAA Student Athlete Eligibility Guide** which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the *OHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the *Handbook* are also posted on the OHSAA website at [ohsaa.org](http://ohsaa.org).


 I understand that an OHSAA member school must **adhere to all rules and regulations** that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.


 I understand that participation in interscholastic athletics is a **privilege not a right**.

**Student Code of Responsibility**


 As a student athlete, I **understand and accept** the following responsibilities:


 I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration.


 I will be **fully responsible** for my own actions and the consequences of my actions.


 I will **respect the property** of others.


 I will **respect and obey the rules** of my school and laws of my community, state and country.


 I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state and country.

 I **understand that a student whose character or conduct violates** the school's Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period as determined by the principal.


 **Informed Consent** – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**


 I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital.


 I **consent to medical treatment** for the student following an injury or illness suffered during practice and/or a contest.


 To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school I **consent to the release to the OHSAA any and all portions of school record files**, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work completed, grades received and attendance data.

 I **consent to the OHSAA's use of the herein named student's name**, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

 I **understand that if I drop a class**, take course work through College Credit Plus, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility. I **accept full responsibility** for compliance with Bylaw 4-4-1, Scholarship, and the passing five credit standard expressed therein.

 I **understand all concussions are potentially serious** and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required in order for the student to return to participation.

 I **have read and signed** the Ohio Department of Health's **Concussion Information Sheet** and have retained a copy for myself.

 **By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.**

**\*Must Be Signed Before Physical Examination**

Student's Signature

Birth date

Grade in School

Date

Parent's or Guardian's Signature

Date