# Ohio High School Athletic Association
# Preparticipation Physical Evaluation

**DATE OF EXAM:**_____ 

**Name** _____ **Sex** _____ **Age** _____ **Date of Birth** _____

**Grade**_____ **School** _____ **Sport(s)** _____

**Address** _____ **Phone** _____

**Personal Physician**_____

***In case of emergency, contact:*** ***Name*** _____***Relationship*** _____

***Phone (H)*** _____***(W)***_____***(Cell)***_____***(Cell)***_____

***Email:*** _____

## History

**This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.**

**Explain "YES" answers in the space provided. Circle questions you don't know the answer to.**

| | | Yes | No |
|---|---|---|---|
| **1.** | Has a doctor ever denied or restricted you participation in sports for any reason? | ☐ | ☐ |
| **2.** | Do you have an ongoing medical condition (like diabetes or asthma)? | ☐ | ☐ |
| **3.** | Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | ☐ | ☐ |
| **4.** | Do you have allergies to medicines, pollens, foods, or stinging insects? | ☐ | ☐ |
| **5.** | Do you think you are in good health? | ☐ | ☐ |
| **6.** | Have you ever passed out or nearly passed out DURING exercise? | ☐ | ☐ |
| **7.** | Have you ever passed out or nearly passed out AFTER exercise? | ☐ | ☐ |
| **8.** | Have you ever had discomfort, pain, or pressure in your chest during exercise? | ☐ | ☐ |
| **9.** | Does your heart race or skip beats during exercise? | ☐ | ☐ |
| **10.** | Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A heart murmur ☐ High Cholesterol ☐ A heart infection | | |
| **11.** | Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) | ☐ | ☐ |
| **12.** | Has anyone in your family died for no apparent reason? | ☐ | ☐ |
| **13.** | Does anyone in your family have a heart problem? | ☐ | ☐ |
| **14.** | Has any family member or relative died of heart problems or of sudden death before age 50? | ☐ | ☐ |
| **15.** | Does anyone in your family have Marfan syndrome? | ☐ | ☐ |
| **16.** | Have you ever spent the night in a hospital? | ☐ | ☐ |
| **17.** | Have you ever had surgery? | ☐ | ☐ |
| **18.** | Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below: | ☐ | ☐ |
| **19.** | Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | ☐ | ☐ |
| **20.** | Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | ☐ | ☐ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Head | Neck | Shoulder | Upper Arm | Elbow | Forearm | Hand / Fingers | Chest |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot / Toes |

| | | | |
|---|---|---|---|
| **21.** | Have you ever had a stress fracture? | ☐ | ☐ |
| **22.** | Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | ☐ | ☐ |
| **23.** | Do you regularly use a brace or assistive device? | ☐ | ☐ |
| **24.** | Has a doctor ever told you that you have asthma or allergies? | ☐ | ☐ |
| **25.** | Do you cough, wheeze, or have difficulty breathing during or after exercise? | ☐ | ☐ |
| **26.** | Is there anyone in your family who has asthma? | ☐ | ☐ |
| **27.** | Have you ever used an inhaler or taken asthma medicine? | ☐ | ☐ |
| **28.** | Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | ☐ | ☐ |
| **29.** | Have you had infectious mononucleosis (mono) within the last month? | ☐ | ☐ |
| **30.** | Do you have any rashes, pressure sores, or other skin problems? | ☐ | ☐ |
| **31.** | Have you had a herpes skin infection? | ☐ | ☐ |
| **32.** | Have you ever had a head injury or concussion? | ☐ | ☐ |
| **33.** | Have you been hit in the head and been confused or lost your memory? | ☐ | ☐ |
| **34.** | Have you ever had a seizure? | ☐ | ☐ |
| **35.** | Do you have headaches with exercise? | ☐ | ☐ |
| **36.** | Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | ☐ | ☐ |
| **37.** | Have you ever been unable to move your arms or legs after being hit or falling? | ☐ | ☐ |
| **38.** | When exercising in the heat, do you have severe muscle cramps or become ill? | ☐ | ☐ |
| **39.** | Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | ☐ | ☐ |
| **40.** | Have you had any problems with your eyes or vision? | ☐ | ☐ |
| **41.** | Do you wear glasses or contact lenses? | ☐ | ☐ |
| **42.** | Do you wear protective eyewear, such as goggles or a face shield? | ☐ | ☐ |
| **43.** | Are you happy with your weight? | ☐ | ☐ |
| **44.** | Are you trying to gain or lose weight? | ☐ | ☐ |
| **45.** | Has anyone recommended you change your weight or eating habits? | ☐ | ☐ |
| **46.** | Do you limit or carefully control what you eat? | ☐ | ☐ |
| **47.** | Do you have any concerns that you would like to discuss with a doctor? | ☐ | ☐ |
| **48.** | Record the dates of your most recent immunizations (shots) Tdap _____ MMR _____ Hepatitis B_____ Chicken Pox _____ Meningococcal_____ | | |

**FEMALES ONLY**

| | | | |
|---|---|---|---|
| **49.** | Have you ever had a menstrual period? | ☐ | ☐ |
| **50.** | How old were you when you had your first menstrual period? | _____ | |
| **51.** | How many periods have you had in the last 12 months? | _____ | |

Explain "Yes" Answers Here: (Attach additional sheets as needed)

_____

_____

_____

_____

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Signature: _____ Signature: _____ Date: _____

Athlete Parent or Guardian (If athlete is under 18)

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

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.
NOTE: HISTORY AND ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION

Modified from 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, 2004. Rev. 03/10

Rev. 2/11

# Physical Examination Form

**The section below is to be completed by physician or staff after history and consent forms are completed.**

**Students Name**_____ **Birth Date**_____

**Height**_____ **Weight**_____ **% Body Fat (optional)**_____ **Pulse**_____ **BP**_____/_____, _____/_____, _____/_____

**Vision R 20/** _____ **L 20/** _____ **Corrected: Y N** **Pupils: Equal** _____ **Unequal** _____

**Follow-Up Questions on More Sensitive Issues (Optional)**

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.

Notes: _____

| MEDICAL | Normal | Abnormal findings | Initials* |
|---|---|---|---|
| Appearance | | | |
| Eyes/ears/nose/throat | | | |
| Hearing | | | |
| Lymph nodes | | | |
| Heart | | | |
| Murmurs | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia (males only) | | | |
| Skin | | | |
| **MUSCULOSKELETAL** | | | |
| Neck | | | |
| Back | | | |
| Shoulder/arm | | | |
| Elbow/forearm | | | |
| Wrist/hand/fingers | | | |
| Hip/thigh | | | |
| Knee | | | |
| Leg/ankle | | | |
| Foot/toes | | | |

*Multiple-examiner set-up only.

Notes: _____

# Clearance

Cleared without restriction

Cleared, with recommendations for further evaluation or treatment for:

Not cleared for: All Sports Certain sports: Reason:

Recommendations:

**Emergency Information:**

Allergies:

Other Information:

Name of Physician: (print/type/stamp) (M.D., D.O., D.C.) Date:

**If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:**

Address: _____ Phone: _____

Signature of Physician: _____ Date: _____

**OHSAA AUTHORIZATION FORM**

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 a 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

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

## 2011-2012 Ohio High School Athletic Association Eligibility and Authorization Statement

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 brochure entitled "Your Athletic Eligibility," 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 web site at www.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 of time 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 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 transported via ambulance to the nearest hospital.
- 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 Post Secondary Enrollment Option, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility.
- 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 competition due to a suspected concussion, he or she will be unable to return to competition that day without the written authorization from a physician (M.D. or D.O.) or an athletic trainer which indicates that the student has not been concussed..
- 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 |
|---|---|

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