

# **Ohio High School Athletic Association**



## PREPARTICIPATION PHYSICAL EVALUATION 2018-2019

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Namo	Exam			Date of birth		
Sex Age Grade School						
				Relationship		
	H) (W) (C					
_		-				7
	icines and Allergies: Please list the prescription and over-the-counter me ently taking	edicines	and sup	plements (herbal and nutritional-including energy drinks/ protein supplements) that you a	are	
-						
Doy	rou have any allergies? TYes No If yes, please identify specific all	ergy bel	OW.			
1 -	Medicines Pollens	Food		☐ Stinging Insects		
	n "Yes" answers below. Circle questions you don't know the a		s to.			_
	ERAL QUESTIONS	Yes	No	BONE AND JOINT QUESTIONS - CONTINUED	Yes	No
1.	, , , , ,			22. Do you regularly use a brace, orthotics, or other assistive device?		
	reason?			23. Do you have a bone, muscle, or joint injury that bothers you?		+
2.	Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections			Do any of your joints become painful, swolllen, feel warm, or look red?     Do you have any history of juvenile arthritis or connective tissue disease?		+
	Other:			25. Do you have any history of juvernie artiffus of conflective fissue disease?		
3.	Have you ever spent the night in the hospital?			MEDICAL QUESTIONS	Yes	No
4.	Have you ever had surgery?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
HEA	RT HEALTH QUESTIONS ABOUT YOU	Yes	No	27. Have you ever used an inhaler or taken asthma medicine?		
5.	Have you ever passed out or nearly passed out DURING or AFTER			28. Is there anyone in your family who has asthma?		
	exercise?			29. Were you born without or are you missing a kidney, an eye, a testicle (males),		_
6.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			your spleen, or any other organ?  30. Do you have groin pain or a painful bulge or hernia in the groin area?		+
7.	Does your heart ever race or skip beats (irregular beats) during exercise?			31. Have you had infectious mononucleosis (mono) within the past month?		+-
8.	Has a doctor ever told you that you have any heart problems? If so, check			32. Do you have any rashes, pressure sores, or other skin problems?		+
0.	all that apply:			33. Have you had a herpes (cold sores) or MRSA (staph) skin infection?	1	+
	☐ High blood pressure ☐ A heart murmur			34. Have you ever had a head injury or concussion?		+
	☐ High cholesterol ☐ A heart infection			35. Have you ever had a hit or blow to the head that caused confusion,		
	☐ Kawasaki disease Other:			prolonged headaches, or memory problems?		
9.	Has a doctor ever ordered a test for your heart? (For example, ECG/EKG,			36. Do you have a history of seizure disorder or epilepsy?		
	echocardiogram)			37. Do you have headaches with exercise?		
10.	Do you get lightheaded or feel more short of breath than expected during exercise?			Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		+
11.	Have you ever had an unexplained seizure?			39. Have you ever been unable to move your arms or legs after being hit or falling?		
12.	Do you get more tired or short of breath more quickly than your friends			40. Have you ever become ill while exercising in the heat?		
	during exercise?			41. Do you get frequent muscle cramps when exercising?		
	RT HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	42. Do you or someone in your family have sickle cell trait or disease?		-
13.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including			43. Have you had any problems with your eyes or vision?  44. Have you had an eye injury?	-	-
	drowning, unexplained car accident, or sudden infant death syndrome)?			44. Have you had an eye injury? 45. Do you wear glasses or contact lenses?	1	+
14.	Does anyone in your family have hypertrophic cardiomyopathy, Marfan			46. Do you wear protective eyewear, such as goggles or a face shield?		+
	syndrome, arryhthmogenic right ventricular cardiomyopathy, long QT			47. Do you worry about your weight?		+
	syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic			48. Are you trying to gain or lose weight? Has anyone recommended that you do?		
	polymorphic ventricular tachycardia?			49. Are you on a special diet or do you avoid certain types of foods?		
15.	Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			50. Have you ever had an eating disorder?  51. Do you have any concerns that you would like to discuss with a doctor?		-
16.	Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			FEMALES ONLY		
DON	E AND JOINT QUESTIONS	Yes	No	<ul><li>52. Have you ever had a menstrual period?</li><li>53. How old were you when you had your first menstrual period?</li></ul>	-	
17.		162	NO	54. How many periods have you had in the last 12 months?		
	caused you to miss a practice or game?			, ,		
18. 19.	Have you ever had any broken or fractured bones or dislocated joints?  Have you ever had an injury that required x-rays, MRI, CT scan, injections,			Explain "yes" answers here		
	therapy, a brace, a cast, or crutches?					
20.	Have you ever had a stress fracture?	ļ				
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)	1	i l			



## **Ohio High School Athletic Association**

# OHSAZ

PREPARTICIPATION PHYSICAL EVALUATION 2018-2019
THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

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PLEASE COMPLETE ONLY IF YOUR STUDENT HAS SPECIAL NEEDS OR A DISABILITY. Date of Exam \_ Name \_\_\_\_ Date of birth \_\_\_\_ \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ \_Sport(s) \_ Type of disability 2. Date of disability 3. Classification (if available) Cause of disability (birth, disease, accident/trauma, other) 5. List the sports you are interested in playing 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? Have you had autonomic dysreflexia? Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia) illness? Do you have muscle spasticity? 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. 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\_



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#### PREPARTICIPATION PHYSICAL EVALUATION 2018-2019

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### PHYSICAL EXAMINATION FORM

Name	Date of birth	

#### PHYSICIAN REMINDERS

- 1. 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?
- 2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION	DATE OF EXAMINATION	1	
Height Weight	□ Male	□ Female	
BP / ( / ) Pulse Vision R	R 20/ L20/	Corrected	□ Y □ N
MEDICAL	NORMAL	ABNO	DRMAL FINDINGS
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			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional			
Duck walk, single leg hop			

<sup>&</sup>lt;sup>a</sup>Consider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.

<sup>&</sup>lt;sup>b</sup>Consider GU exam if in private setting. Having third part present is recommended.

<sup>&</sup>lt;sup>c</sup>Consider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

### PREPARTICIPATION PHYSICAL EVALUATION 2018-2019

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#### **CLEARANCE FORM**

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

Pending further evaluation   For any sports   For certain sports   Reason   Recommendations   Personal Physician or medical examiner (print/type)   Date of Exam   Date of Exam   Phone   Phone   Responsive process   Phone   Phone   Responsive process   Phone   Ph	Name	Sex □ M □ F Age Date of birth				
Cleared for all sports without restriction with recommendations for further evaluation or treatment for	☐ Cleared for all sports without restriction					
Pending further evaluation   For any sports   For certain sports   Reason   Recommendations   Personal Physician or medical examiner (print/type)   Date of Exam   Date of Exam   Phone   Phone   Responsive process   Phone   Phone   Responsive process   Phone   Ph						
For any sports	□ Not Cleared					
Reason	☐ Pending further evaluation					
Reason	☐ For any sports					
If 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)	☐ For certain sports					
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)						
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Name of physician or medical examiner (print/type)	contraindications to practice and participate in the sport(s) as outline the school at the request of the parents. In the event that the examina PPE. If conditions arise after the student has been cleared for participate	ed above. A copy of the physical exam is on record in my office and can be made available to nation is conducted en masse at the school, the school administrator shall retain a copy of the cipation, the physician may rescind the clearance until the problem is resolved and the potential				
Address Phone						
Signature of physician/medical examiner						
EMERGENCY INFORMATION  Personal Physician Phone  In case of Emergency, contact Phone  Allergies	, rudi coc					
Personal Physician Phone In case of Emergency, contact Phone Allergies	Signature of physician/medical examiner	, MD, DO, D.C., P.A. or A.N.P.				
In case of Emergency, contact Phone	EMERGENCY INFORMATION					
Allergies	Personal Physician	Phone				
	In case of Emergency, contact	Phone				
Other Information	Allergies					
Other Information						
Other Information						
	Other Information					