

Ohio High School Athletic Association



PREPARTICIPATION PHYSICAL EVALUATION 2012-2013

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	This form is to be filled out by the student and parent prior to seeing the med		aminer.	The medical examiner should keep this form in the chart.)		
te o	f Exam					-
ex Age Grade School				Sport(s)		
	cines and Allergies: Please list the prescription and over-the-counter med ntly taking	icines a	nd supp	ements (herbal and nutritional-including energy drinks/ protein supplements) that	you are	e
) V(ou have any allergies? ☐ Yes ☐ No If yes, please identify specific aller	av belo	N			
_	Medicines Pollens			☐ Stinging Insects		
	in "Yes" answers below. Circle questions you don't know the a		s to	☐ Stiriging insects		
	ERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	I
				Do you cough, wheeze, or have difficulty breathing during or after exercise?		
	Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?		1
	below: Asthma Anemia Diabetes Infections			28. Is there anyone in your family who has asthma?		t
	Other:			29. Were you born without or are you missing a kidney, an eye, a testicle		
	Have you ever spent the night in the hospital?			(males), your spleen, or any other organ?		1
۸۵	, , ,	Vaa	No	30. Do you have groin pain or a painful bulge or hernia in the groin area? 31. Have you had infectious mononucleosis (mono) within the past month?		\vdash
Aŀ	RT HEALTH QUESTIONS ABOUT YOU Have you ever passed out or nearly passed out DURING or AFTER	Yes	No	31. Have you had infectious mononucleosis (mono) within the past month? 32. Do you have any rashes, pressure sores, or other skin problems?		+
	exercise?			33. Have you had a herpes (cold sores) or MRSA (staph) skin infection?		
	Have you ever had discomfort, pain tightness, or pressure in your chest			34. Have you ever had a head injury or concussion?		
	during exercise?			35. Have you ever had a hit or blow to the head that caused confusion,		
	Does your heart ever race or skip beats (irregular beats) during exercise?			prolonged headaches, or memory problems?		-
	Has a doctor ever told you that you have any heart problems? If so, check all that apply:			36. Do you have a history of seizure disorder or epilepsy? 37. Do you have headaches with exercise?		+
	☐ High blood pressure ☐ A heart murmur			38. Have you ever had numbness, tingling, or weakness in your arms or 38. Have you ever had numbness, tingling, or weakness in your arms or		
	☐ High cholesterol ☐ A heart infection			legs after being hit or falling?		
	□ Kawasaki disease Other:			39. Have you ever been unable to move your arms or legs after being hit or		
	Has a doctor ever ordered a test for your heart? (For example, ECG/EKG,			falling?		
	echocardiogram)			40. Have you ever become ill while exercising in the heat?		
	Do you get lightheaded or feel more short of breath than expected during exercise?			41. Do you get frequent muscle cramps when exercising?		-
	Have you ever had an unexplained seizure?			42. Do you or someone in your family have sickle cell trait or disease?43. Have you had any problems with your eyes or vision?		+
	Do you get more tired or short of breath more quickly than your friends during			44. Have you had an eye injury?		╁
	exercise?			45. Do you wear glasses or contact lenses?		
	RT HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	46. Do you wear protective eyewear, such as goggles or a face shield?		
	Has any family member or relative died of heart problems or had an			47. Do you worry about your weight?		
	unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			48. Are you trying to gain or lose weight? Has anyone recommended that you do?		
	Does anyone in your family have hypertrophic cardiomyopathy, Marfan			49. Are you on a special diet or do you avoid certain types of foods?		
	syndrome, arryhthmogenic right venticular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic			50. Have you ever had an eating disorder?		1
	polymorphic ventricular tachycardia?			51. Do you have any concerns that you would like to discuss with a doctor? FEMALES ONLY		
	Does anyone in your family have a heart problem, pacemaker, or implanted			52. Have you ever had a menstrual period?		
	defibrillator?			53. How old were you when you had your first menstrual period?		
	Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			54. How many periods have you had in the last 12 months?		
NI	E AND JOINT QUESTIONS	Yes	No	Explain "yes" answers here		
	Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?					
	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, therapy, a brace, a cast, or crutches?					
	Have you ever had a stress fracture?					
	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)					
	Do you regularly use a brace, orthotics, or other assistive device?					
	Do you have a bone, muscle, or joint injury that bothers you? Do any of your joints become painful, swolllen, feel warm, or look red?					

Signature of parent/guardian



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THE ATHLETE WITH SPECIAL NEEDS:

ie of Exam me	Date of birth	
Age Grade School	Sport(s)	
Age Glade School	sport(s)	
Type of disability		
Date of disability		
Classification (if available)		
Cause of disability (birth, disease, accident/trauma, other)		
List the sports you are interested in playing		
	Yes	No
Do you regularly use a brace, assistive device or prosthetic?		
Do you use a special brace or assistive device for sports?		
Do you have any rashes, pressure sores, or any other skin problems?		
Do you have a hearing loss? Do you use a hearing aid?		
Do you have a visual impairment?		
Do you have any special devices for bowel or bladder function? Do you have burning or discomfort when urinating?		
Do you have burning or discomfort when urinating?		
Have you had autonomic dysreflexia?		
Have you ever been diagnosed with a heat related (hyperthermia) or co	Id-related (hypothermia) illness?	
Do you have muscle spasticity?		
Do you have frequent seizures that cannot be controlled by medication?	?	
ease indicate if you have ever had any of the following.		
	Yes	No
lantoaxial instability	Yes	No
lantoaxial instability ray evaluation for atlantoaxial instability	Yes	No
lantoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one)	Yes	No
lantoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) ssy bleeding	Yes	No
antoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) sy bleeding larged spleen	Yes	No
antoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) sy bleeding larged spleen epatitis	Yes	No
lantoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) lasy bleeding larged spleen epatitis steopenia or osteoporosis	Yes	No
lantoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) asy bleeding nlarged spleen epatitis steopenia or osteoporosis fficulty controlling bowel	Yes	No
lantoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) asy bleeding nlarged spleen epatitis steepenia or osteoporosis fficulty controlling bowel fficulty controlling bladder	Yes	No
lantoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) asy bleeding nlarged spleen epatitis steopenia or osteoporosis fficulty controlling bowel fficulty controlling bladder umbness or tingling in arms or hands	Yes	No
ease indicate if you have ever had any of the following. Idantoaxial instability Idantoaxial i	Yes	No
lantoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) asy bleeding nlarged spleen epatitis steopenia or osteoporosis fficulty controlling bowel fficulty controlling bladder umbness or tingling in arms or hands umbness or tingling in legs or feet eakness in arms or hands	Yes	No
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lantoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) asy bleeding nlarged spleen epatitis steopenia or osteoporosis fficulty controlling bowel fficulty controlling bladder umbness or tingling in arms or hands umbness or tingling in legs or feet eakness in arms or hands eakness in legs or feet ecent change in coordination ecent change in ability to walk	Yes	No
lantoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) lasy bleeding larged spleen epatitis steopenia or osteoporosis fficulty controlling bowel fficulty controlling bladder lambness or tingling in arms or hands lambness or tingling in legs or feet leakness in arms or hands leakness in legs or feet leacent change in coordination	Yes	No
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antoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) sy bleeding larged spleen repatitis steopenia or osteoporosis fficulty controlling bowel fficulty controlling bladder rembness or tingling in arms or hands rembness or tingling in legs or feet reakness in arms or hands reakness in legs or feet recent change in coordination recent change in ability to walk reakness in bifida	Yes	No
antoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) sy bleeding larged spleen repatitis steopenia or osteoporosis fficulty controlling bowel fficulty controlling bladder rembness or tingling in arms or hands rembness or tingling in legs or feet reakness in arms or hands reakness in legs or feet recent change in coordination recent change in ability to walk reaknessy r	Yes	No
antoaxial instability ray evaluation for atlantoaxial instability slocated joints (more than one) sy bleeding larged spleen patitis teopenia or osteoporosis ficulty controlling bowel ficulty controlling bladder mbness or tingling in arms or hands mbness or tingling in legs or feet eakness in arms or hands eakness in legs or feet cent change in coordination cent change in ability to walk ina bifida tex allergy	Yes	No
antoaxial instability ay evaluation for atlantoaxial instability allocated joints (more than one) sy bleeding larged spleen patitis teopenia or osteoporosis ficulty controlling bowel ficulty controlling bladder mbness or tingling in arms or hands mbness or tingling in legs or feet eakness in arms or hands eakness in legs or feet cent change in coordination cent change in ability to walk ina bifida lex allergy	Yes	No



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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			
Height Weight	□ Male	□ Female	
BP / (/) Pulse Vision R 20/	L20/	Corrected	□ Y □ N
MEDICAL	NORMAL	ABNORMA	AL 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			

^aConsider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third part present is recommended.

^cConsider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

PREPARTICIPATION PHYSICAL EVALUATION 2012-2013

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	
$\hfill \Box$ Cleared for all sports without restriction with recommendations for further	r evaluation or treatment for
□ Not Cleared	
☐ Pending further evaluation	
☐ For any sports	
☐ For certain sports	
Reason	
Recommendations	
to practice and participate in the sport(s) as outlined above. A copy of t request of the parents. In the event that the examination is conducted earise after the student has been cleared for participation, the physician completely explained to the athlete (and parents/guardians).	sipation physical evaluation. The student does not present apparent clinical contraindications the physical exam is on record in my office and can be made available to the school at the en masse at the school, the school administrator shall retain a copy of the PPE. If conditions may rescind the clearance until the problem is resolved and the potential consequences are
	Date of Exam Phone
Address	Filolie
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 2012-2013

I hereby authorize the release and disclosure of the personal health information of ______ ("Student"),

as described below, to	("Scnool").
physical education teacher, school nurse or other mem	e School principal or assistant principal, athletic director, coach, athletic trainer, ber of the School's administrative staff as necessary to evaluate the Student's including but not limited to interscholastic sports programs, physical education
to determine the Student's eligibility to participate in scl Evaluation form or other similar document required by to classroom or other School sponsored activities; records	be released and disclosed includes records of physical examinations performed mool sponsored activities, including but not limited to the Pre-participation the School prior to determining eligibility of the Student to participate in soft the evaluation, diagnosis and treatment of injuries which the Student including but not limited to practice sessions, training and competition; and other cal fitness to participate in school sponsored activities.
physicians; a physician or other health care profession Student's eligibility to participate in certain school spon such activities, whether or not such physicians or other	be released or disclosed to the School by the Student's personal physician or all retained by the School to perform physical examinations to determine the sored activities or to provide treatment to students injured while participating in health care professionals are paid for their services or volunteer their time to the health care professional who evaluates, diagnoses or treats an injury or other school sponsored activities.
make certain decisions about the Student's health and that the School is a not a health care provider or health described below may be redisclosed and may not conti	zation to release or disclose the personal health information described above to ability to participate in certain school sponsored and classroom activities, and plan covered by federal HIPAA privacy regulations, and the information inue to be protected by the federal HIPAA privacy regulations. I also understand a that govern the privacy of educational records, and that the personal health protected by those regulations.
	plans may not condition the provision of treatment or payment on the signing of in certain school sponsored activities may be conditioned on the signing of this
	ing at any time, except to the extent that action has been taken by a health care written revocation to the school principal (or designee) whose name and address
Name of Principal:	
School Address:	
This authorization will expire when the student is no lor	nger enrolled as a student at the school.
	GE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS
Student's Signature	Birth date of Student, including year
Name of Student's personal representative, if applicabl I am the Student's (check one): Parent _	e Legal Guardian (documentation must be provided)
Signature of Student's personal representative, if applic	cable Date

2012-2013 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.

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.

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.

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