

Ohio High School Athletic Association



Date:

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PREPARTICIPATION PHYSICAL EVALUATION 2012-2013

HISTORY FORM

(Note: This form is to be filled out by the student and parent prior to seeing the	medical examiner.	The medical examiner should keep this form in the chart.)	
Date of Exam			
Name		Date of birth	
Sex Age Grade School		Sport(s)	
Address			
Emergency Contact		Relationship	
Phone (H) (W)	(Cell)	(Email)	
F			
Medicines and Allergies: Hease list the prescription and over-the-counter r currently taking	nedicines and supp	vements (herbal and nutritional-including energy drinks/ protein supplements) that you are	e
Do you have any allergies? Yes No If yes, please identify specific a	digraubday		
	Food	Stinging Insects	
Explain "Yes" answers below. Circle questions you don't knowth	e answers to.		
1. Has a doctor ever denied or restricted your participation in sports for any	S. Barrah Antaile	22. Do you regularly use a brace, orthotics, or other assistive device?	Santo inte Santa
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	-+	24. Do any of your joints become painful, swollen, feel warm, or look red?	
below. Asthma Anemia Diabetes Infections		25. Do you have any history of juvenile arthritis or connective tissue disease?	
Other		ang ana ang ang ang ang ang ang ang ang	Contraction Internation
A Have you ever spent the night in the hospital? Have you ever had surgery?			
4. nave you ever had surgery?	STRUKTOR BANON	26. Do you cough, wheeze, or have difficulty breathing during or after exercise? 27. Have you ever used an inhaler or taken asthma medicine?	
5. Have you ever passed out or nearly passed out DURING or AFTER	the discount attenuities	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 disconfort, pain tightness, or pressure in your chest		your spleen, or any other organ?	
during exercise?		30. Do you have groin pain or a painful bulge or hemia in the groin area?	
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?	
all that apply.		33. Have you had a herpes (cold sores) or MRSA (staph) skin infection?	
High blood pressure A heart murrur		34. Have you ever had a head injury or concussion?	
High cholesterol A heart infection		35. Have you ever had a hit or blowto the head that caused confusion,	
□ Kawasaki disease Other. 9. Has a dodor ever ordered a test for your heart? (For example, EOG/EKG,	•+	prolonged headaches, or memory problems? 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		38. Have you ever had numbress, tingling, or weakness in your arms or	
exercise?		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?	
	Section and the	42. Do you or someone in your family have sickle cell trait or disease?	
 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)?		45. Do you wear glasses or contact lenses?	
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan		46. Do you wear protective eyewear, such as goggles or a face shield?	
syndrome, anyhthmogenic right venticular 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	1 L	50. Have you ever had an eating disorder?	
defibrillator?		51. Do you have any concerns that you would like to discuss with a doctor?	200.002703
 Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? 		52. Have you ever had a menstrual period?	20200-0000-000-002-022
		53. Howold were you when you had your first menstrual period?	
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that		54. How many periods have you had in the last 12 months?	
caused you to miss a practice or game?			
18. Have you ever had any broken or fractured bones or dislocated joints?		Explain 'yes'' answers here	
19. Have you ever had an injury that required x-rays, MFI, CT scan, injections,			
therapy, a brace, a cast, or crutches?			
20. 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) 			

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 The student has family insurance Ves No If yes, family insurance company name and policy number.

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Ohio High School Athletic Association



PREPARTICIPATION PHYSICAL EVALUATION 2012-2013

THE ATHLETE WITH SPECIAL NEEDS:

SUPPLEMENTAL HISTORY FORM

Date of Exam_

Name				Date of birth
Sex	Age	_Grade	School	Spott(s)

1.	Type of disability
2.	Date of disability
З.	Classification (if available)
4.	Cause of disability (birth, disease, accident/trauma, other)
5.	List the sports you are interested in playing
12/2	₩ A
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 disconfort when urinating?
13.	Have you had autonomic dysreflexia?
14.	Have you ever been diagnosed with a heat related (hyperthernia) or cold-related (hypothernia) illness?
15.	Do you have muscle spasticity?
16.	Do you have frequent seizures that cannot be controlled by medication?
E	sin U.s. all and and the second

Explain 'yes' answers here

Please indicate if you have ever had any of the following. 6 T Spinor 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 Numbnessor tingling in legs or feet Weaknessin 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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Date of birth ____

PREPARTICIPATION PHYSICAL EVALUATION 2012-2013

PHYSICAL EXAMINATION FORM

Name_

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).

A CONTRACTOR OF			
Height Weight	⊡ Male	🗆 Female	
BP / (/) Pulse Vision R 20/	L20/	Corrected	
			an a
Appearance			
Marfan stigmeta (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly,			
arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat			
Pupils equal			
Hearing			
Lymph nodes			
Heat			
Mumurs (auscultation standing, supine, +/- Valsalva)			
Location of the point of maximal impulse (PM)			
Pulses			
Simultaneous ferroral and radial pulses			
Lungs			
Abdomen		•	
Genitourinary (males only)			
Skin			
HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic			
Neck			
Back			
Shoulder/arm			
Elbowforearm			
Wist/hand/fingers			
Hipthigh			
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 examili in private setting. Having third part present is recommended.

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

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REPARTICIPATION	PHYSICAL	EVALUATION	2012-2013
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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 f	for further evaluation or treatment for
Not Cleared	
Pending further evaluation	
□ For any sports	
For certain sports	
Reason	
to practice and participate in the sport(s) as outlined above. A request of the parents. In the event that the examination is cor arise after the student has been cleared for participation, the pl completely explained to the athlete (and parents/guardians).	preparticipation physical evaluation. The student does not present apparent clinical contraindications A copy of the physical examis on record in my office and can be made available to the school at the inducted en masse at the school, the school administrator shall retain a copy of the PPE. If conditions physician may rescind the clearance until the problem is resolved and the potential consequences are
	Date of Exam
Address	Phone
Signature of physician/medical examiner	, MD, DO, D.C., P.A. or A.N.P.
EVERGENCY INFORMATION	
Personal Physician	Phone
In case of Emergency, contact	Phone
Allergies	
Other Information	
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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 ______("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: ______

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

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
- uill 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.

U 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