# Ohio High School Athletic Association

## PREPARTICIPATION PHYSICAL EVALUATION 2012-2013

(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) ___________________________

---

## 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 taking:

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Pollens</th>
<th>Food</th>
<th>Stinging Insects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below:

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

---

## 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:

   ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other:

3. Have you ever spent the night in the hospital?

   Yes ☐ No ☐

4. Have you ever had surgery?

   Yes ☐ No ☐

---

## HEART HEALTH QUESTIONS

5. Have you ever passed out or nearly passed out DURING or AFTER exercise?

   Yes ☐ No ☐

6. Have you ever had heart palpitations, pain tightness, or pressure in your chest during exercise?

   Yes ☐ No ☐

7. Does your heart 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 ☐ Heart murmur
   ☐ High cholesterol ☐ 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 ☐

---

## 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 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 gout or a painful bunion or hemiar in the gout 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. Have you ever used anabolic steroids or other drugs that cause muscle cramps or heat cramps?

    Yes ☐ No ☐

42. Do you have an eating disorder?

    Yes ☐ No ☐

43. Have you ever had an eating disorder?

    Yes ☐ No ☐

44. Do you worry about your weight?

    Yes ☐ No ☐

45. Do you wear protective eyewear, such as goggles or face shield?

    Yes ☐ No ☐

46. Do you use protective equipment, such as face or head gear?

    Yes ☐ No ☐

47. Do you use protective equipment, such as face or head gear?

    Yes ☐ No ☐

48. Do you have any abnormalities of the testicles (males), or have you had a testicular exam?

    Yes ☐ No ☐

49. Do you have any conditions that would prevent you from participating in sports?

    Yes ☐ No ☐

50. Do you have any conditions that would prevent you from participating in sports?

    Yes ☐ No ☐

51. Do you have any concerns that you would like to discuss with a doctor?

    Yes ☐ No ☐

---

## FE/MALLES 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 ☐

---

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:

---

©2013 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment. -Revised 3/12
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

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/truma, other)
5. List the sports you are interested in playing

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: ________________________
**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**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>☐ Male</th>
<th>☐ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BP</th>
<th>( / )</th>
<th>Pulse</th>
<th>Vision R 20/</th>
<th>L20/</th>
<th>Corrected</th>
<th>☐ Y</th>
<th>☐ N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL**

<table>
<thead>
<tr>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
</table>

- **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**

<table>
<thead>
<tr>
<th>MUSCULOSKELETAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
</tr>
<tr>
<td>Back</td>
</tr>
<tr>
<td>Shoulder/arm</td>
</tr>
<tr>
<td>Elbow/forearm</td>
</tr>
<tr>
<td>Wrist/hand/fingers</td>
</tr>
<tr>
<td>Hip/thigh</td>
</tr>
<tr>
<td>Knee</td>
</tr>
<tr>
<td>Leg/ankle</td>
</tr>
<tr>
<td>Foot/toes</td>
</tr>
<tr>
<td>Functional</td>
</tr>
</tbody>
</table>
  - 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 preparticipation 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 __________________________________________________________

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment. -Revised 3/12
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: ______________________________________________________
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 Signature of Student's personal representative, if applicable
I am the Student's (check one): _______ Parent _______ Legal Guardian (documentation must be provided)

_________ 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.

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

<table>
<thead>
<tr>
<th>Student’s Signature</th>
<th>Birth date</th>
<th>Grade in School</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent’s or Guardian’s Signature</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rev. 3/12