



Ohio High School Athletic Association Preparticipation Physical Evaluation



DATE OF EXAM: _____

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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.

- | | | | | | | | | | | | | | | | | | |
|---|------------|----------|-----------|-----------|-----------|----------------|----------------|-------|------------|------------|-----|-------|------|-----------|-------|-------------|---|
| <p>1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No</p> <p>2. Do you have an ongoing medical condition (like diabetes or asthma)? <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? <input type="checkbox"/> <input type="checkbox"/></p> <p>4. Do you have allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> <input type="checkbox"/></p> <p>5. Do you think you are in good health? <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>8. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Does your heart race or skip beats during exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Has a doctor ever told you that you have (check all that apply):</p> <p style="padding-left: 20px;"><input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur</p> <p style="padding-left: 20px;"><input type="checkbox"/> High Cholesterol <input type="checkbox"/> A heart infection</p> <p>11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) <input type="checkbox"/> <input type="checkbox"/></p> <p>12. Has anyone in your family died for no apparent reason? <input type="checkbox"/> <input type="checkbox"/></p> <p>13. Does anyone in your family have a heart problem? <input type="checkbox"/> <input type="checkbox"/></p> <p>14. Has any family member or relative died of heart problems or of sudden death before age 50? <input type="checkbox"/> <input type="checkbox"/></p> <p>15. Does anyone in your family have Marfan syndrome? <input type="checkbox"/> <input type="checkbox"/></p> <p>16. Have you ever spent the night in a hospital? <input type="checkbox"/> <input type="checkbox"/></p> <p>17. Have you ever had surgery? <input type="checkbox"/> <input type="checkbox"/></p> <p>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: <input type="checkbox"/> <input type="checkbox"/></p> <p>19. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: <input type="checkbox"/> <input type="checkbox"/></p> <p>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: <input type="checkbox"/> <input type="checkbox"/></p> <table border="1" style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="width: 8%;">Head</td> <td style="width: 8%;">Neck</td> <td style="width: 12%;">Shoulder</td> <td style="width: 8%;">Upper Arm</td> <td style="width: 8%;">Elbow</td> <td style="width: 12%;">Forearm</td> <td style="width: 8%;">Hand / Fingers</td> <td style="width: 8%;">Chest</td> </tr> <tr> <td>Upper back</td> <td>Lower back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/shin</td> <td>Ankle</td> <td>Foot / Toes</td> </tr> </table> <p>21. Have you ever had a stress fracture? <input type="checkbox"/> <input type="checkbox"/></p> <p>22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> <input type="checkbox"/></p> <p>23. Do you regularly use a brace or assistive device? <input type="checkbox"/> <input type="checkbox"/></p> <p>24. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> <input type="checkbox"/></p> | Head | Neck | Shoulder | Upper Arm | Elbow | Forearm | Hand / Fingers | Chest | Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot / Toes | <p>25. Do you cough, wheeze, or have difficulty breathing during or after exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>26. Is there anyone in your family who has asthma? <input type="checkbox"/> <input type="checkbox"/></p> <p>27. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> <input type="checkbox"/></p> <p>28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> <input type="checkbox"/></p> <p>29. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> <input type="checkbox"/></p> <p>30. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> <input type="checkbox"/></p> <p>31. Have you had a herpes skin infection? <input type="checkbox"/> <input type="checkbox"/></p> <p>32. Have you ever had a head injury or concussion? <input type="checkbox"/> <input type="checkbox"/></p> <p>33. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> <input type="checkbox"/></p> <p>34. Have you ever had a seizure? <input type="checkbox"/> <input type="checkbox"/></p> <p>35. Do you have headaches with exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> <input type="checkbox"/></p> <p>37. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> <input type="checkbox"/></p> <p>38. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> <input type="checkbox"/></p> <p>39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> <input type="checkbox"/></p> <p>40. Have you had any problems with your eyes or vision? <input type="checkbox"/> <input type="checkbox"/></p> <p>41. Do you wear glasses or contact lenses? <input type="checkbox"/> <input type="checkbox"/></p> <p>42. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> <input type="checkbox"/></p> <p>43. Are you happy with your weight? <input type="checkbox"/> <input type="checkbox"/></p> <p>44. Are you trying to gain or lose weight? <input type="checkbox"/> <input type="checkbox"/></p> <p>45. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> <input type="checkbox"/></p> <p>46. Do you limit or carefully control what you eat? <input type="checkbox"/> <input type="checkbox"/></p> <p>47. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> <input type="checkbox"/></p> <p>48. Record the dates of your most recent immunizations (shots)</p> <p style="padding-left: 20px;">Tdap _____ MMR _____ Hepatitis B _____</p> <p style="padding-left: 20px;">Chicken Pox _____ Meningococcal _____</p> |
| Head | Neck | Shoulder | Upper Arm | Elbow | Forearm | Hand / Fingers | Chest | | | | | | | | | | |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot / Toes | | | | | | | | | | |

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: _____
Athlete

Signature: _____ Date: _____
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

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/yrebs/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

