

Ohio High School Athletic Association http://www.ohsanotg/medicine/PPE_2013-14.pdf

PREPARTICIPATION PHYSICAL EVALUATION March 2013-June 2014

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Varme				Date of birth		
	Age Grade School				_	
	ss				_	
merç	pency Contact:			Relationship		
Phone	e (H) (W)	(Cell) _		(Email)		_
Med cum	licines and Allergies: Please list the prescription and over-the-counter ma ently taking	edicines	and sup	plements (herbal and nutritional-including energy drinks/ protein supplements) that you a	are	
Doy	ou have any allergies? Yes No If yes, please identify specific all	ergy bel	low.			
	Medicines Pollens	Food		☐ Stinging Insects		
Expla	in "Yes" answers below. Circle questions you don't know the		ers to.			
	ERAL QUESTIONS	Yes		BONE AND JOINT QUESTIONS - CONTINUED	Yes	No
1.	The second secon			22. Do you regularly use a brace, orthotics, or other assistive device?		1
	reason?			23. Do you have a bone, muscle, or joint injury that bothers you?		I
2.	Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections			24. Do any of your joints become painful, swolllen, feel warth, or look red?		
	below: Asthma Anemia Diabetes Infections Other:			25. Do you have any history of juvenile arthritis or connective tissue disease?		
3.	Have you ever spent the night in the hospital?	-		MEDICAL QUESTIONS	1 1/2	1 41
4.		-		26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes	No
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?		1
	exercise?			29. Were you born without or are you missing a kidney, an eye, a testide (males),		
6.	Have you ever had discomfort, pain, tightness, or pressure in your chest			your spleen, or any other organ?		
7	during exercise?			30. Do you have groin pain or a painful bulge or hernia in the groin area?		
8.	Does your heart ever race or skip beats (irregular beats) during exercise? Has a doctor ever told you that you have any heart problems? If so, check	-		31. Have you had infectious mononucleosis (mono) within the past month? 32. Do you have any rashes, pressure sores or other skin problems?		
U.	all that apply:			Do you have any rashes, pressure sores, or other skin problems? Have you had a herpes (cold sores) or MRSA (staph) skin infection?	ļ	+-
	☐ High blood pressure ☐ A heart murrur		- 0	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?	1	+
	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.				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?		
EICAI	during exercise? RT HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	At Victoria	41. Do you get frequent muscle cramps when exercising?		
13.	Has any family member or relative died of heart problems or had an	Yes	NO	42. Do you or someone in your family have sickle cell trait or disease?	ļ	_
10.	unexpected or unexplained sudden death before age 50 (including			Have you had any problems with your eyes or vision? 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, arryhthmogenic right ventricular cardiomyopathy, long QT			47. Do you worry about your weight?		
	syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymonohic ventricular tachycardia?			48. Are you trying to gain or lose weight? Has anyone recommended that you do?		
15.	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			49. Are you on a special diet or do you avoid certain types of foods?		
10.	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,			FEMALES ONLY	46/00/00	NAME OF THE PARTY
	or near drowning?			52. Have you ever had a menstrual period?		
	E AND JOINT QUESTIONS	Yes	No	53. How old 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?		
10	caused you to miss a practice or game?					
	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, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?					
20.	Have you ever had a stress fracture?					
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)		21			

The student has family insurance Yes No If yes, family insurance company name and policy number:

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PREPARTICIPATION PHYSICAL EVALUATION March 2013-June 2014 THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

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ite d			Date of birth	
		School		
^ _	Age crace		441(5)	
1.	Type of disability			
2.	Date of disability			
3.	Classification (if available)			
4.	Cause of disability (birth, disease, accide	ent/trauma, other)		
5.	List the sports you are interested in playing	ng		
			Yes	No
6.	Do you regularly use a brace, assistive d	levice or prosthetic?		
'.	Do you use a special brace or assistive of	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?			
١.	Do you have any special devices for bow	vel or bladder function?		
2	Do you have burning or discomfort when	urinating?		
3.	Have you had autonomic dysreflexia?			
4.	Have you ever been diagnosed with a he	eat related (hyperthermia) or cold-related (hypothermia) illn	iess?	
5.	Do you have muscle spasticity?			
3.	Do you have frequent seizures that cannot	ot be controlled by medication?		
ı				
ß	e indicate if you have ever had any of th	he following.	Yes	No
tla	toaxial instability	he following.	Yes	No
tla -ra	toaxial instability revaluation for atlantoaxial instability	he following.	Yes	No
tla (-ra	toaxial instability vevaluation for atlantoaxial instability cated joints (more than one)	he following.	Yes	No
Atla (-ra Disl	toaxial instability evaluation for atlantoaxial instability cated joints (more than one) bleeding	he following.	Yes	No
tla -ra isl	toaxial instability revaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen	he following.	Yes	No
ttla (-ra Disl as	toaxial instability r evaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen tittis	he following.	Yes	No
tla (-ra Disl as Inla Jep	toaxial instability r evaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen tititis openia or osteoporosis	he following.	Yes	No
ttla (-ra Disl as Inla lep Osta	toaxial instability revaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen titis openia or osteoporosis ulty controlling bowel	he following.	Yes	No
ttla (-ra Disl Disl Distribution	toaxial instability revaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen tittis openia or osteoporosis ulty controlling bowel ulty controlling bladder	he following.	Yes	No
Atla (-ra Disl Disl Diffi Diffi Jur	toaxial instability revaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen tittis openia or osteoporosis ulty controlling bowel ulty controlling bladder oness or tingling in arms or hands	he following.	Yes	No .
tla (-ra Disl Disl Distribution Difficultur	toaxial instability revaluation for atlantcaxial instability cated joints (more than one) bleeding ged spleen utitis openia or osteoporosis ulty controlling bowel ulty controlling bladder oness or tingling in arms or hands oness or tingling in legs or feet		Yes	No .
ttla i-ra isli ias inla lep Ostr iffi ittli iur	toaxial instability revaluation for atlantcaxial instability cated joints (more than one) bleeding ged spleen utitis openia or osteoporosis ulty controlling bowel ulty controlling bladder oness or tingling in arms or hands oness or tingling in legs or feet oness in arms or hands	he following.	Yes	No
tla (-ra Disl ias inla lep Ostri Diffi Jur Vea Vea	toaxial instability revaluation for atlantcaxial instability cated joints (more than one) bleeding ged spleen tititis openia or osteoporosis ulty controlling bowel ulty controlling bladder oness or tingling in arms or hands oness or tingling in legs or feet sness in arms or hands oness in arms or hands		Yes	No
ttla islas inla ker ker ker ker	toaxial instability revaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen tittis openia or osteoporosis ulty controlling bowel ulty controlling bladder oness or tingling in arms or hands oness or tingling in legs or feet aness in arms or hands oness in legs or feet ont change in coordination		Yes	No
ttla i-ra inla inla inla inffi inffi iur iur iur iur iur iur iec iec iec iec iec iec iec iec iec iec	toaxial instability revaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen tittis openia or osteoporosis ulty controlling bowel ulty controlling bladder oness or tingling in arms or hands oness or tingling in legs or feet sness in arms or hands oness in legs or feet ont change in coordination ont change in ability to walk		Yes	No
ttla (-ra Xisl as Enla Jur Ver Ver Ver Ver Ver	toaxial instability revaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen tittis openia or osteoporosis ulty controlling bowel ulty controlling bladder oness or tingling in arms or hands oness or tingling in legs or feet sness in arms or hands oness in legs or feet ont change in coordination ont change in ability to walk a bifida		Yes	No
tla inla inla inla inla inffi inffi inffi inffi inffi inffi inffi inffi inffi inf	toaxial instability revaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen tittis openia or osteoporosis ulty controlling bowel ulty controlling bladder oness or tingling in arms or hands oness or tingling in legs or feet oness in arms or hands oness in legs or feet ont change in coordination ont change in ability to walk a bifida callergy		Yes	No
ttla (-ra Disk as inka Diffi Diffi Jur Vea Vea Reco	toaxial instability revaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen tittis openia or osteoporosis ulty controlling bowel ulty controlling bladder oness or tingling in arms or hands oness or tingling in legs or feet sness in arms or hands oness in legs or feet ont change in coordination ont change in ability to walk a bifida		Yes	No
atta Arabista	toaxial instability revaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen tittis openia or osteoporosis ulty controlling bowel ulty controlling bladder oness or tingling in arms or hands oness or tingling in legs or feet oness in arms or hands oness in legs or feet ont change in coordination ont change in ability to walk a bifida callergy			No
Atla K-ra	toaxial instability revaluation for atlantoaxial instability cated joints (more than one) bleeding ged spleen tittis openia or osteoporosis ulty controlling bowel ulty controlling bladder oness or tingling in arms or hands oness or tingling in legs or feet oness in arms or hands oness in legs or feet ont change in coordination ont change in ability to walk a bifida callergy			No
ittla islandist	toaxial instability revaluation for atlantcaxial instability cated joints (more than one) bleeding ged spleen tititis openia or osteoporosis ulty controlling bowel ulty controlling bladder oness or tingling in arms or hands oness or tingling in legs or feet oness in arms or hands oness in arms or hands oness in legs or feet ent change in coordination ont change in ability to walk a bifida or allergy uin "yes" answers here			No



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PHYSICAL EXAMINATIO	N	FORM
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Valle	Date of birth	
N ROLO AND DESCRIPTION		

PHYSICIAN REMINDERS

- 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 digarettes, 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).

EXAMINAT	ION															
Height					Weight					Vale	□ Female					
BP		(1)	Pulse		Visio	on R 20/	I	20/	Corre	cted	□ Y	′ □ N		
MEDICAL		To the								NORMAL		ABNO	RMAL FI	NDINGS		
Appearano																Military Landingson
	igmata (kyphos						rachnodact	yly,								
	>height, hyper	faxity, my	opia, M	VP, ao	rtic insufficie	ncy)										
Eyes/ears/r			*													
Pupils ed	qual															
Hearing																
Lymph nod	es ·															
Heart																
	(auscultation st				salva)											
	of the point of n	naximal in	rpulse (PM)												
Pulses																
	eous femoral ar	nd radial p	ulses						,					-		
Lungs														-		
Abdomen		÷														
	iry (males only)			-											No. of the last section of	
Skin																
	sions suggest	ive of MF	RSA, tir	nea co	orporis											
Neurologia		5 - 2 - 2 - 2 - 2 - 1 - 1 - 1 - 1 - 1 - 1		100												
	SKELETAL	0)2(5)						at the								Helding Still 1
Neck																
Back															***	
Shoulder/a																
Ebow/fore					*											
Wrist/hand	d/fingers															
Hip/thigh													5			
Knee																
Leg/ankle																
Foot/toes																
Functional																
Duck wa	alk, single leg l	hop														

^aConsider EOG, 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.

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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	Date of birth
☐ Cleared for all sports without restriction		
☐ Cleared for all sports without restriction with recommend	lations for further evaluation or treatment for	
□ Not Cleared		
☐ Pending further evaluation		
☐ For any sports		
☐ For certain sports		
request of the parents. In the event that the examination arise after the student has been cleared for participation completely explained to the athlete (and parents/guardia Name of physician or medical examiner (print/type)	n is conducted en masse at the school, the sc n, the physician may rescind the clearance unt ans).	d in my office and can be made available to the school at the hool administrator shall retain a copy of the PPE. If conditions til 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.
EMERGENCY INFORMATION		
Personal Physician		Phone
In case of Emergency, contact		Phone
Allergies		
Other Information		
		·
COMPANIE OF THE STATE OF THE ST		
4 of 6		3/1/13-11:07 AM

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 2013-2014

I hereby authorize the release and dis	sclosure of the personal ("School").	health information of	("Student"), as described below, to
	School's administrative	staff as necessary to evaluate the S	athletic director, coach, athletic trainer, physical education teacher, Student's eligibility to participate in school sponsored activities, classroom activities.
eligibility to participate in school spon School prior to determining eligibility (sored activities, includir of the Student to particip nt incurred while engagin	ng but not limited to the Pre-participa pate in classroom or other School sp ng in school sponsored activities, in	ts of physical examinations performed to determine the Student's ation Evaluation form or other similar document required by the consored activities; records of the evaluation, diagnosis and cluding but not limited to practice sessions, training and competition of sponsored activities.
health care professional retained by t activities or to provide treatment to str	he School to perform ph udents injured while par o the School; or any oth	nysical examinations to determine th ticipating in such activities, whether er EMT, hospital, physician or other	the Student's personal physician or physicians; a physician or other ne Student's eligibility to participate in certain school sponsored or not such physicians or other health care professionals are paid for r health care professional who evaluates, diagnoses or treats an
the Student's health and ability to par covered by federal HIPAA privacy rec	ticipate in certain school pulations, and the inform d that the School is cove	I sponsored and classroom activitie ration described below may be redis ered under the federal regulations th	health information described above to make certain decisions abouts, and that the School is a not a health care provider or health plan schosed and may not continue to be protected by the federal HIPAA nat govern the privacy of educational records, and that the personal
I also understand that health care pro the Student's participation in certain s	viders and health plans school sponsored activiti	may not condition the provision of t ies may be conditioned on the signi	reatment or payment on the signing of this authorization; however, ng of this authorization.
I understand that I may revoke this au authorization, by sending a written re			action has been taken by a health care provider in reliance on this and address appears below.
Name of Princip	oal:		
School Address	S:		
This authorization will expire when the	e student is no langer er	nrolled as a student at the school	
	18 YEARS OF AGE, T	THIS AUTHORIZATION MUST BE S	SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. II RIZATION PERSONALLY.
Student's Signature	*		Birth date of Student, including year
Name of Student's personal represen	tative, if applicable		
I am the Student's (check one):	Parent	_Legal Guardian (documentation m	nust be provided)
Signature of Student's personal repre	sentative, if applicable		Date

2013-2014 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 Student Athlete Eligibility Guide 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.
 - l 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 treatment by medical personnel and 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 treated and transported via ambulance to the nearest hospital.
- Consent to medical treatment for the student following an injury or illness suffered during practice and/or a contest.
- 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 practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required in order for the student to return to participation.
- I have read and signed the Ohio Department of Health's Concussion Information Sheet and have retained a copy for myself.

 By signing this we acknowledge that we have read the above information and that we consent to the berein named stude
- 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	