



Ohio High School Athletic Association Preparticipation Physical Evaluation



DATE OF EXAM: _____

Page 1 of 4

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.

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No
 2. Do you have an ongoing medical condition (like diabetes or asthma)?
 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?
 4. Do you have allergies to medicines, pollens, foods, or stinging insects?
 5. Do you think you are in good health?
 6. Have you ever passed out or nearly passed out DURING exercise?
 7. Have you ever passed out or nearly passed out AFTER exercise?
 8. Have you ever had discomfort, pain, or pressure in your chest during exercise?
 9. Does your heart race or skip beats during exercise?
 10. Has a doctor ever told you that you have (check all that apply):
 High Blood Pressure A heart murmur
 High Cholesterol A heart infection
 11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)
 12. Has anyone in your family died for no apparent reason?
 13. Does anyone in your family have a heart problem?
 14. Has any family member or relative died of heart problems or of sudden death before age 50?
 15. Does anyone in your family have Marfan syndrome?
 16. Have you ever spent the night in a hospital?
 17. Have you ever had surgery?
 18. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:
 19. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:
 20. Have you had a bone or joint injury that required x-rays, MRI, C.T., surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:
- | | | | | | | | |
|------------|------------|----------|-----------|-------|-----------|----------------|-------------|
| Head | Neck | Shoulder | Upper Arm | Elbow | Forearm | Hand / Fingers | Chest |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot / Toes |
21. Have you ever had a stress fracture?
 22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
 23. Do you regularly use a brace or assistive device?
 24. Has a doctor ever told you that you have asthma or allergies?

25. Do you cough, wheeze, or have difficulty breathing during or after exercise?
26. Is there anyone in your family who has asthma?
27. Have you ever used an inhaler or taken asthma medicine?
28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?
29. Have you had infectious mononucleosis (mono) within the last month?
30. Do you have any rashes, pressure sores, or other skin problems?
31. Have you had a herpes skin infection?
32. Have you ever had a head injury or concussion?
33. Have you been hit in the head and been confused or lost your memory?
34. Have you ever had a seizure?
35. Do you have headaches with exercise?
36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
37. Have you ever been unable to move your arms or legs after being hit or falling?
38. When exercising in the heat, do you have severe muscle cramps or become ill?
39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
40. Have you had any problems with your eyes or vision?
41. Do you wear glasses or contact lenses?
42. Do you wear protective eyewear, such as goggles or a face shield?
43. Are you happy with your weight?
44. Are you trying to gain or lose weight?
45. Has anyone recommended you change your weight or eating habits?
46. Do you limit or carefully control what you eat?
47. Do you have any concerns that you would like to discuss with a doctor?
48. Record the dates of your most recent immunizations (shots):
 Tdap _____ MMR _____ Hepatitis B _____
 Chicken Pox _____ Meningococcal _____

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: _____ Parent or Guardian (if athlete is under 18)
 Date: _____

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**

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2004. Rev. 03/10

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 ever feel sad or hopeless most of the time?
- 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 ever think of suicide?
- 4. Have you ever tried to hurt yourself or keep yourself or others from going to school?
- 5. During the past 12 weeks, did you ever have thoughts of suicide or self-harm?
- 6. During the past 12 weeks, have you had at least 1 week of alcohol?
- 7. Have you ever taken alcohol pills or drugs without a doctor's prescription?
- 8. Have you ever taken any supplements to help you gain weight or lose weight or improve your performance?
- 9. Have you ever taken any supplements to help you perform better in sports? (http://www.fda.gov/healthy/healthyproducts/submit.asp?submit=1) (http://www.fda.gov/healthy/healthyproducts/submit.asp?submit=1) (http://www.fda.gov/healthy/healthyproducts/submit.asp?submit=1)

Notes: _____

| MEDICAL | Normal | Abnormal findings | Initials |
|------------------------|--------|-------------------|----------|
| Appearance | | | |
| Eyes/ears/nose/throat | | | |
| Heart | | | |
| 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 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

2011-2012 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. Further, I acknowledge that discussion took place and materials were provided to me on this topic by my school.

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

BARBERTON CITY SCHOOLS
SCHOOL DISTRICT

STUDENT NAME _____

ADDRESS _____

TELEPHONE _____

SCHOOL ATTENDED _____

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

PART I OR II MUST BE COMPLETED

PART I TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (phone number) or _____

Other parent or guardian at _____ (phone number) have been unsuccessful, I hereby give my consent for:

(1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or

Dr. _____ (preferred dentist) or in the event the designated preferred practitioner is not available, by another

licensed physician or dentist and (2) the transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concerning the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

DATE _____

PARENT OR GUARDIAN SIGNATURE _____

ADDRESS _____

DO NOT COMPLETE PART III IF YOU COMPLETED PART I

PART II REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment to be provided in the event of illness or injury requiring emergency treatment. I wish the school authorities to take no action or to:

DATE _____

PARENT OR GUARDIAN SIGNATURE _____

ADDRESS _____

Due to the missing child act we are required to ask for more detailed emergency information to keep in a confidential file in our building. This is for your students safety in the event of an emergency or illness. Please complete everything that pertains to your family if this information changes during the school year please notify the office as soon as possible.

Does the student live with both natural parents? _____

If divorced or separated, who has custody of this student? _____

Who does the student live with? _____

Name of Mother _____ Home Phone _____

Where employed _____ Work Phone _____

Name of Stepmother _____ Home Phone _____

Where employed _____ Work Phone _____

Name of Father _____ Home Phone _____

Where employed _____ Work Phone _____

Name of Stepfather _____ Home Phone _____

Where employed _____ Work Phone _____

Please list two (2) persons other than parents that can be contacted in the event that none of the above noted persons can be reached.
THIS IS EXTREMELY IMPORTANT

| Name | Relationship | Phone |
|-------|--------------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list any other information that you feel might help the school in the event of an emergency concerning your child

BARBERTON CITY SCHOOLS

BARBERTON, OHIO

DRUG TESTING POLICY
GENERAL AUTHORIZATION FORM

I understand that my performance as a participant in an extra-curricular activity and the reputation of the Barberton City Schools are dependent, in part, on my conduct as an individual. I hereby agree to accept and abide by the policies, standards, rules, and regulations set forth by the Barberton City Schools Board of Education and the Barberton High School Athletic Department.

I authorize the Barberton City School's Athletic Department to conduct a urinalysis for drugs and a screening for alcohol abuse. I authorize the Barberton City School District to conduct random tests during the current sports season. I further authorize the release of information to the Barberton City School District (all designated administrative personnel) and to the parents and/or guardian of the student.

This shall be deemed consent pursuant to the Family Educational Rights And Privacy Act and HIPAA regulations for the release of all information to the parties named above.

Student Signature

Date

Parent Signature

Date

"BARBERTON HIGH SCHOOL"

"ATHLETIC INSURANCE WAIVER"

ALL STUDENTS PARTICIPATING IN ATHLETICS MUST BE COVERED BY INSURANCE IN CASE OF INJURY. STUDENTS WITHOUT INSURANCE COVERAGE WILL NOT BE PERMITTED TO PARTICIPATE. INSURANCE COVERAGE MUST BE IN EFFECT PRIOR TO TRY-OUT(S) OR PARTICIPATION IN THEIR RESPECTIVE SPORT.

"PLEASE NOTE OPTIONS"

- 1) We the parents/guardians _____ release the Barberton city Schools from any and all financial responsibilities as a result of any and all injuries incurred by our son/daughter as a direct result of his/her participation in interscholastic athletics.

We certify that such injuries which might be sustained by our son/daughter as a result of participation in interscholastic athletics, are covered by family medical insurance.

Signature of Parent

Name of Provider

Signature of Student

Date

- 2) We certify that our son/daughter has school insurance that covers interscholastic sports participation.