Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2019-2020

(Note: This form is to be filled out by the student and parent prior to seeing the medical examiner.)

Date of Exam

Name

Sex

Age

Grade

School

Sport(s)

Address

Emergency Contact:

Phone (H) (W) (Cell) (Email)

Date of birth

Relationship

Medications 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.

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

□ Medicines □ Pollen □ Food □ Singing Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

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, Allergies, 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 ABOUT YOU

5. Have you ever taken or nearly passed out during or after exercise? □ Yes □ No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? □ Yes □ No

7. Does your heart ever 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 □ A heart murmur
   □ High cholesterol □ A 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

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? □ Yes □ No

14. Does anyone in your family have hypertension, cardiomyopathy, Marfan syndrome, anginal dysrhythmia, right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? □ Yes □ No

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? □ Yes □ No

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? □ Yes □ No

BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game? □ Yes □ No

18. Have you ever had any broken or fractured bones or dislocated joints? □ Yes □ No

19. Have you ever had an injury that required x-rays, MRI, CT scans, injections, therapy, a brace, a cast, or cortisone? □ Yes □ No

20. Have you ever had a stress fracture? □ Yes □ No

21. Have you ever been told that you have or or have you had an x-ray for neck instability or ankle/foot instability? (Down syndrome or cerebral palsy) □ 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 an inhaler or taken asthma medication? □ 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 pain or a painful bunion or herna in your groin 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. Have you had a history of seizures 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 able to move your arms or legs after being hit or falling? □ Yes □ No

40. Have you ever become dehydrated while exercising in the heat? □ Yes □ No

41. Do you get frequent muscle cramps when exercising? □ Yes □ No

42. Do you or someone in your family have sickle cell trait or disease? □ Yes □ No

43. Have you had any problems with your vision or hearing? □ Yes □ No

44. Have you had an eye injury? □ Yes □ No

45. Do you wear glasses or contact lenses? □ Yes □ No

46. Do you wear protective eyewear such as goggles or a face shield? □ Yes □ No

47. Do you worry about your weight? □ Yes □ No

48. Are you trying to gain or lose weight? Has anyone recommended that you do? □ Yes □ No

49. Are you on a special diet or do you avoid certain types of foods? □ Yes □ No

50. Have you ever had an eating disorder? □ Yes □ No

51. Do you have any concerns that you would like to discuss with a doctor? □ Yes □ No

FEMALES 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

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: __________________________ Date: __________________________

Signature of parent/guardian: __________________________

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

Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2019-2020

THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

Please complete only if your student has special needs or a disability.

Date of Exam: ____________________________

Name: ___________________________________

Date of birth: ____________________________

Sex: ___________________ Grade: _________ School: ____________________

1. Type of Disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth disease, accident/trauma, other)
5. List the sports you are interested in playing

6. Do you regularly use a brace, assistive device or prosthesis? ______ Yes ______ No

7. Do you use a special brace or assistive device for sports? ______ Yes ______ No

8. Do you have any rashes, pressure sores, or any other skin problems? ______ Yes ______ No

9. Do you have hearing loss? Do you use a hearing aid? ______ Yes ______ No

10. Do you have a visual impairment? ______ Yes ______ No

11. Do you have any special devices for bowel or bladder function? ______ Yes ______ No

12. Do you have burns or discomfort when urinating? ______ Yes ______ No

13. Have you had appendicitis? ______ Yes ______ No

14. Have you ever been diagnosed with a heat-related (hypoalbuminemia) or cold-related (hypothermia) illness? ______ Yes ______ No

15. Do you have muscle spasms? ______ Yes ______ No

16. Do you have frequent seizures that cannot be controlled by medication? ______ Yes ______ No

Explain "yes" answers here

Please indicate if you have ever had any of the following:

<table>
<thead>
<tr>
<th>Condition/Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
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<tr>
<td>Clubfoot joints (more than one)</td>
<td></td>
<td></td>
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<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
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<tr>
<td>Enlarged spleen</td>
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<td></td>
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<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cataracts or cataract surgery</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty controlling bowel movements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
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<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in legs or feet</td>
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<td></td>
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<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
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<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
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<tr>
<td>Spina bifida</td>
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<td></td>
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<tr>
<td>Latex allergy</td>
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</tbody>
</table>

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: ____________________________

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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).

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>DATE OF EXAMINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>Weight</td>
</tr>
<tr>
<td>BP</td>
<td>I</td>
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<tr>
<td>Pulse</td>
<td></td>
</tr>
<tr>
<td>Vision R 20/60</td>
<td></td>
</tr>
<tr>
<td>L20/60</td>
<td>Corrected</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marfan syndrome (thoracic aorta, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>arm span &gt; height, hyperelasticity, myopia, MVP, aortic insufficiency</td>
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<td></td>
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<tr>
<td>Eyes/ears/nose/throat</td>
<td></td>
<td></td>
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<tr>
<td>Pupils equal</td>
<td></td>
<td></td>
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<tr>
<td>Hearing</td>
<td></td>
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<tr>
<td>Lymph nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Murmur (auscultation standing, supine, T-Valsalva)</td>
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<td></td>
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<tr>
<td>Location of the point of maximal impulse (P1-M)</td>
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<td></td>
</tr>
<tr>
<td>Pulses</td>
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<td></td>
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<tr>
<td>Simultaneous femoral and radial pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gentitourinary (males only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSV, lesions suggestive of MRSA, linea corpora</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| MUSCULOSKELETAL | |
| Neck            | | |
| Back            | | |
| Shoulder/arm    | | |
| Elbow/forearm   | | |
| Wrist/hand/fingers | | |
| Hip/thigh       | | |
| Knee            | | |
| Leg/ankle       | | |
| Foot/toes       | | |
| Functional      | | |
| Duck walk, single leg hop | | |

*Consider EKG, echocardiogram, or referral to cardiologist for abnormal cardiac history or exam.
*Consider GU exam if private setting. Having three or more present is recommended.
*Consider cognitive or baseline neuropsychometric 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 □ 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 pre-participation 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 parent/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 ____________________________________________