**PREPARTICIPATION PHYSICAL EVALUATION – Ohio High School Athletic Association – 2020-2021**

**PHYSICAL EXAMINATION FORM**

Name: _______________________________ Date of birth: _______________________________

**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, e-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-enhancing 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, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height:</td>
<td>Weight</td>
<td></td>
</tr>
<tr>
<td>BP: / ( / )</td>
<td>Pulse:</td>
<td>Vision: R 20/</td>
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</tbody>
</table>

**MEDICAL**

**Appearance**
- Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)

**Eyes, ears, nose, and throat**
- Pupils equal
- Hearing

**Lymph nodes**

**Heart**
- Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)

**Lungs**

**Abdomen**

**Skin**
- Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis

**Neurological**

**MUSCULOSKELETAL**

**Neck**

**Back**

**Shoulder and arm**

**Elbow and forearm**

**Wrist, hand, and fingers**

**Hip and thigh**

**Knee**

**Leg and ankle**

**Foot and toes**

**Functional**
- Double-leg squat test, single-leg squat test, and box drop or step drop test

*Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): __________________________ Date: ________________

Address: __________________________ Phone: __________________________

Signature of health care professional: __________________________ MD, DO, DC, NP, or PA

PREPARTICIPATION PHYSICAL EVALUATION – OHIO HIGH SCHOOL ATHLETIC ASSOCIATION – 2020-21

MEDICAL ELIGIBILITY FORM

Name: ___________________________ Date of birth: ___________________________

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

__________________________________________________________

☐ Medically eligible for certain sports

__________________________________________________________

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: ____________________________________________

__________________________________________________________

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): ___________________________ Date: ___________________________

Address: ___________________________________________ Phone: ___________________________

Signature of health care professional: ___________________________, MD, DO, DC, NP, or PA

__________________________________________________________

SHAREO EMERGENCY INFORMATION

Allergies: __________________________________________

__________________________________________________________

Medications: __________________________________________

__________________________________________________________

Other information: _______________________________________

__________________________________________________________

Emergency contacts: ______________________________________

__________________________________________________________