



# Ohio High School Athletic Association



## PREPARTICIPATION PHYSICAL EVALUATION 2019-2020 HISTORY FORM

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

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Email) \_\_\_\_\_

**Medicines 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  Pollens  Food  Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
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)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
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)		

BONE AND JOINT QUESTIONS - CONTINUED	Yes	No
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the past month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes (cold sores) or MRSA (staph) skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?		
36. Do you have a history of seizure disorder or epilepsy?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had an eye injury?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to gain or lose weight? Has anyone recommended that you do?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

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: \_\_\_\_\_

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



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 \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Table with 16 rows of questions and two columns for 'Yes' and 'No' answers. Questions include: 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 prosthetic?, 7. Do you use a special brace or assistive device for sports?, 8. Do you have any rashes, pressure sores, or any other skin problems?, 9. Do you have a hearing loss? Do you use a hearing aid?, 10. Do you have a visual impairment?, 11. Do you have any special devices for bowel or bladder function?, 12. Do you have burning or discomfort when urinating?, 13. Have you had autonomic dysreflexia?, 14. Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia) illness?, 15. Do you have muscle spasticity?, 16. Do you have frequent seizures that cannot be controlled by medication?

Explain "yes" answers here

Blank lines for explaining "yes" answers.

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

Table with 17 rows of conditions and two columns for 'Yes' and 'No' answers. Conditions include: Atlantoaxial instability, X-ray evaluation for atlantoaxial instability, Dislocated joints (more than one), Easy bleeding, Enlarged spleen, Hepatitis, Osteopenia or osteoporosis, Difficulty controlling bowel, Difficulty controlling bladder, Numbness or tingling in arms or hands, Numbness or tingling in legs or feet, Weakness in arms or hands, Weakness in legs or feet, Recent change in coordination, Recent change in ability to walk, Spina bifida, Latex allergy.

Explain "yes" answers here

Blank lines for explaining "yes" answers.

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: \_\_\_\_\_



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, 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 with columns for EXAMINATION, DATE OF EXAMINATION, and ABNORMAL FINDINGS. Rows include Height, Weight, BP, Pulse, Vision, and various medical and musculoskeletal categories.

aConsider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
bConsider GU exam if in private setting. Having third part present is recommended.
cConsider cognitive or baseline neuropsychiatric testing if a history of significant concussion.



**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 2019-2020**

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**

