



PREPARTICIPATION PHYSICAL EVALUATION 2019-2020

HISTORY FORM - Please be advised that this paper form is no longer the OHSAA standard.

(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.

Table with 3 columns: Question, Yes, No. Includes sections: GENERAL QUESTIONS, HEART HEALTH QUESTIONS ABOUT YOU, HEART HEALTH QUESTIONS ABOUT YOUR FAMILY, BONE AND JOINT QUESTIONS.

Table with 3 columns: Question, Yes, No. Includes questions 22-25: BONE AND JOINT QUESTIONS - CONTINUED.

Table with 3 columns: Question, Yes, No. Includes sections: MEDICAL QUESTIONS, MENSTRUATION.

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

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 _____ Age _____ Grade _____ School _____ Sport(s) _____

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		
		Yes	No
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

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

		Yes	No
	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

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

- 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		DATE OF EXAMINATION	
Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female
BP / (/)	Pulse	Vision R 20/	L20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL		NORMAL	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat Pupils equal Hearing			
Lymph nodes			
Heart Murmurs (auscultation standing, supine, +/- Valsalva) Location of the point of maximal impulse (PMI)			
Pulses Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional Duck walk, single leg hop			

*Consider ECG, 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.

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 parents/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 _____