Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2018-2019

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.

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: ☐ 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)		
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, arryhthmogenic 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, swolllen, 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: _____.

Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2018-2019

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

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).

EXAMINATION			**DATE OF EXAMINATION** _____
Height	Weight	☐ Male ☐ Female	
BP / (/)	Pulse	Vision R 20/ L20/	Corrected ☐ Y ☐ 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			

[a]Consider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third part present is recommended.
[c]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 _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____