Ohio High School Athletic Association
Preparticipation Physical Evaluation

DATE OF EXAM:_____

Name _____ **Sex** _____ **Age** _____ **Date of Birth** _____

Grade_____ **School** _____ **Sport(s)** _____

Address _____ **Phone** _____

Personal Physician_____

In case of emergency, contact: ***Name*** _____***Relationship*** _____

Phone (H) _____***(W)***_____***(Cell)***_____***(Cell)***_____

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers in the space provided. Circle questions you don't know the answer to.

		Yes	No
1.	Has a doctor ever denied or restricted you participation in sports for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Do you think you are in good health?	☐	☐
6.	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
7.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9.	Does your heart race or skip beats during exercise?	☐	☐
10.	Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A heart murmur ☐ High Cholesterol ☐ A heart infection		
11.	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
12.	Has anyone in your family died for no apparent reason?	☐	☐
13.	Does anyone in your family have a heart problem?	☐	☐
14.	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15.	Does anyone in your family have Marfan syndrome?	☐	☐
16.	Have you ever spent the night in a hospital?	☐	☐
17.	Have you ever had surgery?	☐	☐
18.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
19.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
20.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand / Fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot / Toes

21.	Have you ever had a stress fracture?	☐	☐
22.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
23.	Do you regularly use a brace or assistive device?	☐	☐
24.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
25.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
26.	Is there anyone in your family who has asthma?	☐	☐
27.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
28.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
29.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
30.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
31.	Have you had a herpes skin infection?	☐	☐
32.	Have you ever had a head injury or concussion?	☐	☐
33.	Have you been hit in the head and been confused or lost your memory?	☐	☐
34.	Have you ever had a seizure?	☐	☐
35.	Do you have headaches with exercise?	☐	☐
36.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
37.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
38.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
39.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40.	Have you had any problems with your eyes or vision?	☐	☐
41.	Do you wear glasses or contact lenses?	☐	☐
42.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
43.	Are you happy with your weight?	☐	☐
44.	Are you trying to gain or lose weight?	☐	☐
45.	Has anyone recommended you change your weight or eating habits?	☐	☐
46.	Do you limit or carefully control what you eat?	☐	☐
47.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY

48.	Have you ever had a menstrual period?	☐	☐
49.	How old were you when you had your first menstrual period?	_____	
50.	How many periods have you had in the last 12 months?	_____	

Explain "Yes" Answers Here: (Attach additional sheets as needed)

_____

_____

_____

_____

_____

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Signature: _____ Signature: _____ Date: _____

Athlete Parent or Guardian (If athlete is under 18)

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

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.
NOTE: HISTORY AND ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2004. Rev. 03/06

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

Students Name_____ **Birth Date**_____

Height_____ **Weight**_____ **% Body Fat** (optional)_____ **Pulse**_____ **BP**_____/_____, _____/_____, _____/_____

Vision R 20/ _____ **L 20/** _____ **Corrected: Y N Pupils: Equal** _____ **Unequal** _____

Follow-Up Questions on More Sensitive Issues (Optional)

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.

Notes: _____

MEDICAL	Normal	Abnormal findings	Initials*
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

Notes: _____

Clearance

☐ Cleared without restriction

☐ Cleared, with recommendations for further evaluation or treatment for: _____

☐ Not cleared for: ☐ All Sports ☐ Certain sports: _____ Reason: _____

Recommendations: _____

Emergency Information:

Allergies: _____

Other Information: _____

Name of Physician: (print/type/stamp) _____ (M.D., D.O., D.C.) Date: _____

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

Address: _____ Phone: _____

Signature of Physician: _____