**PREPARTICIPATION PHYSICAL EVALUATION | OHIO HIGH SCHOOL ATHLETIC ASSOCIATION | 2026-27**

# HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)*

| | Not at all | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

| GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.) | Yes | No |
|---|---|---|
| 1. Do you have any concerns that you would like to discuss with your provider? | | |
| 2. Has a provider ever denied or restricted your participation in sports for any reason? | | |
| 3. Do you have any ongoing medical issues or recent illness? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 4. Have you ever passed out or nearly passed out during or after exercise? | | |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | | |
| 7. Has a doctor ever told you that you have any heart problems? | | |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. | | |

| HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*) | Yes | No |
|---|---|---|
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise? | | |
| 10. Have you ever had a seizure? | | |

| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY | Unsure | Yes | No |
|---|---|---|---|
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? | | | |
| 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardio-myopathy (HCM), Marfan syndrome, arrhyth-mogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? | | | |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | | | |

| BONE AND JOINT QUESTIONS | Yes | No |
|---|---|---|
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | | |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? | | |

| MEDICAL QUESTIONS | Yes | No |
|---|---|---|
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ? | | |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | | |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)? | | |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | | |
| 21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? | | |
| 22. Have you ever become ill while exercising in the heat? | | |
| 23. Do you or does someone in your family have sickle cell trait or disease? **Unsure** | | |
| 24. Have you ever had or do you have any problems with your eyes or vision? | | |

| MEDICAL QUESTIONS (*CONTINUED*) | Yes | No |
|---|---|---|
| 25. Do you worry about your weight? | | |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? | | |
| 28. Have you ever had an eating disorder? | | |

| MENSTRUAL QUESTIONS | N/A | Yes | No |
|---|---|---|---|
| 29. Have you ever had a menstrual period? | | | |
| 30. How old were you when you had your first menstrual period? | | | |
| 31. When was your most recent menstrual period? | | | |
| 32. How many periods have you had in the past 12 months? | | | |

**Explain "Yes" answers here.**

**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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# ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name:_____ Date of birth: _____

| |
|---|
| 1. Type of disability: |
| 2. Date of disability: |
| 3. Classification (if available): |
| 4. Cause of disability (birth, disease, injury, or other): |
| 5. List the sports you are playing: |

| | Yes | No |
|---|---|---|
| 6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities? | | |
| 7. Do you use any special brace or assistive device for sports? | | |
| 8. Do you have any rashes, pressure sores, or 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 use 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 as having 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 whether you have ever had any of the following conditions:**

| | Yes | No |
|---|---|---|
| Atlantoaxial instability | | |
| Radiographic (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 questions on this form are complete and correct.**

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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## PREPARTICIPATION PHYSICAL EVALUATION | 2026-27

# PHYSICAL EXAMINATION FORM

Name: _____ Date of Birth: _____ Year of Graduation: _____

### *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).

| EXAMINATION | | |
|---|---|---|
| Height: Weight: | | |
| BP: / ( / ) Pulse: Vision: R 20/ L 20/ Corrected: □ Y □ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | | |
| Eyes, ears, nose, and throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart[a]<br>• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | | |
| Lungs | | |
| Abdomen | | |
| Skin<br>• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis | | |
| Neurological | | |
| **MUSCULOSKELETAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Neck | | |
| Back | | |
| Shoulder and arm | | |
| Elbow and forearm | | |
| Wrist, hand, and fingers | | |
| Hip and thigh | | |
| Knee | | |
| Leg and ankle | | |
| Foot and toes | | |
| Functional<br>• Double-leg squat test, single-leg squat test, and box drop or step drop test | | |

[a] *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

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PREPARTICIPATION PHYSICAL EVALUATION | OHIO HIGH SCHOOL ATHLETIC ASSOCIATION | 2026-27

# MEDICAL ELIGIBILITY FORM

Name: _____ Date of Birth: _____ Year of Graduation: _____

☐ 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 of Exam: _____

Address: _____ Phone: _____

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

## SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

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## PREPARTICIPATION PHYSICAL EVALUATION | 2026 – 2027

### 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 | 2026 – 2027

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**

# PREPARTICIPATION PHYSICAL EVALUATION | 2026 – 2027

## 2026-2027 Ohio High School Athletic Association Eligibility and Authorization Statement

*This document is to be signed by the participant from an OHSAA member school and by the participant's guardian*

I have read, understand and acknowledge receipt of the **OHSAA Student Eligibility Guide and Checklist** (https://ohsaaweb.blob.core.windows.net/files/Eligibility/OtherEligibiltyDocs/EligibilityGuideHS.pdf) which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the *OHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the *Handbook* are also posted on the OHSAA website at ohsaa.org.
I understand that an OHSAA member school must **adhere to all rules and regulations** that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.
I understand that participation in interscholastic athletics is a **privilege not a right**.

**Student Code of Responsibility**

As a student athlete, I **understand and accept** the following responsibilities:

- I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration.
- I will be **fully responsible** for my own actions and the consequences of my actions.
- I will **respect the property** of others.
- I will **respect and obey the rules** of my school and laws of my community, state and country.
- I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state and country.
- I **understand that a student whose character or conduct violates** the school's Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period as determined by the principal.

**Informed Consent –** By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**

- I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital.
- I **consent to medical treatment** for the student following an injury or illness suffered during practice and/or a contest.
- To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school, I **consent to the release to the OHSAA any and all portions of school record files**, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s)or guardian(s), enrollment documents, financial and scholarship records, residence address of the student, academic work completed, grades received and attendance data.
- I **consent to the OHSAA's use of the herein named student's name**, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.
- I **understand that if I drop a class**, take course work through College Credit Plus, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility. **I accept full responsibility** for compliance with Bylaw 4-4, Scholarship, and the passing five credit standard expressed therein.
- I **understand all concussions are potentially serious** and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or another health care provider working under the supervision of a physician will be required in order for the student to return to participation.
- I **have read and signed** the Ohio Department of Health's **Concussion Information Sheet** and have retained a copy for myself.
- I **have read and signed** the Ohio Department of Health's **Sudden Cardiac Arrest Information Sheet** and have retained a copy for myself.

**By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.**

***Must Be Signed Before Physical Examination**

_____

Student's Signature | Birth Date | Year of Graduation | Date

_____

Parent's or Guardian's Signature | Date