OHIO HIGH SCHOOL ATHLETIC ASSOCIATION
STUDENT PARTICIPATION AND PHYSICAL EXAM FORM

PLEASE TYPE OR PRINT:

STUDENT'S NAME____ BIRTH DATE____________ SEX_____ GRADE______
LAST FIRST M.I.

CITY__________________________ SCHOOL____________________________________ PLACE OF BIRTH_______________

STUDENT'S ADDRESS____
STREET CITY ZIP

PARENT(S) NAME____

ADDRESS (IF DIFFERENT THAN STUDENT)____
STREET

____ HOME TELEPHONE PHONE NO.________________________
CITY ZIP

FAMILY PHYSICIAN'S NAME, ADDRESSS, PHONE NUMBER____

ATHLETE'S HISTORY

	YES	NO
1. HAS THIS ATHLETE EVER HAD A HOSPITALIZATION, SURGERY, INJURY, OR SERIOUS MEDICAL ILLNESS?	____	____
2. IS THIS ATHLETE NOW UNDER THE CARE OF A PHYSICIAN OR TAKING ANY MEDICATION?........................	____	____
3. HAS ANY PHYSICIAN EVER RECOMMENDED OR DO YOU FEEL THAT THERE SHOULD BE LIMITS PLACED ON PARTICIPATION IN COMPETITIVE SPORTS?..	____	____
4. DOES THIS ATHLETE HAVE ANY KNOWN ALLERGIES TO MEDICATIONS?..	____	____
5. DOES THIS ATHLETE WEAR GLASSES OR CONTACT LENSES? GIVE DATE OF LAST EYE EXAM IF "YES"......	____	____
6. HAS THIS ATHLETE EVER BLACKED OUT OR LOST CONCIOUSNESS DURING PHYSICAL ACTIVITY?..............	____	____

IF YES, PLEASE SPECIFY

WE CONSENT TO THE PARTICIPATION OF THE ABOVE NAMED STUDENT IN THE INTERSCHOLASTIC PROGRAM OF HIS/HER SCHOOL, INCLUDING PRACTICE SESSIONS AND TRAVEL TO AND FROM ATHLETIC CONTEST. WE ALSO AGREE TO EMERGENCY MEDICAL TREATMENT AS DEEMED NECESSARY BY THE PHYSICIANS DESIGNATED BY SCHOOL AUTHORITIES.

______________________________ ______________________________ ____________
STUDENT PARENT DATE

HISTORY AND CONSENT MUST BE COMPLETED PRIOR TO THE PHYSICAL EXAMINATION

HEALTH EXAMINATION FORM

STUDENT'S NAME____GRADE_______

HEIGHT____________________ WEIGHT_____________ BP_________PULSE___________

ABNORMAL PHYSICAL FINDINGS:

OPTIONAL TESTS:
URINALYSIS
ALUMINUM____
SUGAR____
MICRO(IF ABOVE TEST ABNORMAL)
____
BLOOD COUNT
(FOR FEMALES)
HGR____
OR
HCT____

SHOULD THERE BE ANY LIMITATIONS PLACED ON ATHLETIC PARTICIPATION?.. YES ____ NO ____

RECOMMENDATIONS:

I CERTIFY THAT I HAVE ON THIS DATE EXAMINED THIS STUDENT AND THAT ON THE BASIS OF THE EXAMINATION REQUIRED BY THE SCHOOL AUTHORITIES AND THE STUDENT'S MEDICAL HISTORY AS FURNISHED TO ME, I HAVE FOUND NO REASON WHICH WOULD MAKE IT MEDICALLY INADVISABLE FOR THIS STUDENT TO COMPETE IN SUPERVISED ATHLETIC ACTIVITIES. (NOTE EXCEPTIONS ABOVE)

PHYSICIAN'S NAME AND ADDRESS (STAMP OR PRINT)

PHYSICIAN'S SIGNATURE_______________________________

PHYSICIAN'S TELEPHONE NO___________________________

DATE____

(HISTORY AND CONSENT MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION)