



Ohio High School Athletic Association



PREPARTICIPATION PHYSICAL EVALUATION 2017-2018

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: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> 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, arrhythmogenic 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, swollen, 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 2017-2018

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 _____



Ohio High School Athletic Association



PREPARTICIPATION PHYSICAL EVALUATION 2017-2018

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.

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 2017-2018

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 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

2017-2018 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 parent.

I have read, understand and acknowledge receipt of the OHSAA Student Athlete Eligibility Guide 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), 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 4-4-1, 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 an athletic trainer 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.

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 Grade in School Date

Parent's or Guardian's Signature Date

Ohio Department of Health Concussion Information Sheet

For Interscholastic Athletics

Dear Parent/Guardian and Athletes,

This information sheet is provided to assist you and your child in recognizing the signs and symptoms of a concussion. Every athlete is different and responds to a brain injury differently, so seek medical attention if you suspect your child has a concussion. Once a concussion occurs, it is very important your athlete return to normal activities slowly, so he/she does not do more damage to his/her brain.

What is a Concussion?

A concussion is an injury to the brain that may be caused by a blow, bump, or jolt to the head. Concussions may also happen after a fall or hit that jars the brain. A blow elsewhere on the body can cause a concussion even if an athlete does not hit his/her head directly. Concussions can range from mild to severe, and athletes can get a concussion even if they are wearing a helmet.

Signs and Symptoms of a Concussion

Athletes do not have to be "knocked out" to have a concussion. In fact, less than 1 out of 10 concussions result in loss of consciousness. Concussion symptoms can develop right away or up to 48 hours after the injury. Ignoring any signs or symptoms of a concussion puts your child's health at risk!

Signs Observed by Parents of Guardians

- ◆ *Appears dazed or stunned.*
- ◆ *Is confused about assignment or position.*
- ◆ *Forgets plays.*
- ◆ *Is unsure of game, score or opponent.*
- ◆ *Moves clumsily.*
- ◆ *Answers questions slowly.*
- ◆ *Loses consciousness (even briefly).*
- ◆ *Shows behavior or personality changes (irritability, sadness, nervousness, feeling more emotional).*
- ◆ *Can't recall events before or after hit or fall.*

Symptoms Reported by Athlete

- ◆ *Any headache or "pressure" in head. (How badly it hurts does not matter.)*
- ◆ *Nausea or vomiting.*
- ◆ *Balance problems or dizziness.*
- ◆ *Double or blurry vision.*
- ◆ *Sensitivity to light and/or noise*
- ◆ *Feeling sluggish, hazy, foggy or groggy.*
- ◆ *Concentration or memory problems.*
- ◆ *Confusion.*
- ◆ *Does not "feel right."*
- ◆ *Trouble falling asleep.*
- ◆ *Sleeping more or less than usual.*

Be Honest

Encourage your athlete to be honest with you, his/her coach and your health care provider about his/her symptoms. Many young athletes get caught up in the moment and/or feel pressured to return to sports before they are ready. It is better to miss one game than the entire season... or risk permanent damage!

Seek Medical Attention Right Away

Seeking medical attention is an important first step if you suspect or are told your child has a concussion. A qualified health care professional will be able to determine how serious the concussion is and when it is safe for your child to return to sports and other daily activities.

- ◆ *No athlete should return to activity on the same day he/she gets a concussion.*
- ◆ *Athletes should **NEVER** return to practices/games if they still have ANY symptoms.*
- ◆ *Parents and coaches should never pressure any athlete to return to play.*

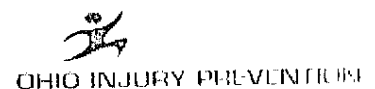
The Dangers of Returning Too Soon

Returning to play too early may cause Second Impact Syndrome (SIS) or Post-Concussion Syndrome (PCS). SIS occurs when a second blow to the head happens before an athlete has completely recovered from a concussion. This second impact causes the brain to swell, possibly resulting in brain damage, paralysis, and even death. PCS can occur after a second impact. PCS can result in permanent, long-term concussion symptoms. The risk of SIS and PCS is the reason why no athlete should be allowed to participate in any physical activity before they are cleared by a qualified healthcare professional.

Recovery

A concussion can affect school, work, and sports. Along with coaches and teachers, the school nurse, athletic trainer, employer, and other school administrators should be aware of the athlete's injury and their roles in helping the child recover.

During the recovery time after a concussion, physical and mental rest are required. A concussion upsets the way the brain normally works and causes it to work longer and harder to complete even simple tasks. Activities that require concentration and focus may make symptoms worse and cause the brain to heal slower. Studies show that children's brains take several weeks to heal following a concussion.



Returning to Daily Activities

1. Be sure your child gets plenty of rest and enough sleep at night – no late nights. Keep the same bedtime weekdays and weekends.
2. Encourage daytime naps or rest breaks when your child feels tired or worn-out.
3. Limit your child's activities that require a lot of thinking or concentration (including social activities, homework, video games, texting, computer, driving, job-related activities, movies, parties). These activities can slow the brain's recovery.
4. Limit your child's physical activity, especially those activities where another injury or blow to the head may occur.
5. Have your qualified health care professional check your child's symptoms at different times to help guide recovery.

Returning to Learn (School)

1. Your athlete may need to initially return to school on a limited basis, for example for only half-days, at first. This should be done under the supervision of a qualified health care professional.
2. Inform teacher(s), school counselor or administrator(s) about the injury and symptoms. School personnel should be instructed to watch for:
 - a. Increased problems paying attention.
 - b. Increased problems remembering or learning new information.
 - c. Longer time needed to complete tasks or assignments.
 - d. Greater irritability and decreased ability to cope with stress.
 - e. Symptoms worsen (headache, tiredness) when doing schoolwork.
3. Be sure your child takes multiple breaks during study time and watch for worsening of symptoms.
4. If your child is still having concussion symptoms, he/she may need extra help with school-related activities. As the symptoms decrease during recovery, the extra help or supports can be removed gradually.
5. For more information, please refer to Return to Learn on the ODH website.

Resources

ODH Violence and Injury Prevention Program
<http://www.healthy.ohio.gov/vipp/child/returntolearn/>

Centers for Disease Control and Prevention
<http://www.cdc.gov/headsap/braininjury/>

National Federation of State High School Associations
www.nfhs.org

Brain Injury Association of America
www.biausa.org/

Returning to Play

1. Returning to play is specific for each person, depending on the sport. Starting 4/26/13, Ohio law requires written permission from a health care provider before an athlete can return to play. Follow instructions and guidance provided by a health care professional. It is important that you, your child and your child's coach follow these instructions carefully.
2. Your child should NEVER return to play if he/she still has ANY symptoms. (Be sure that your child does not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration).
3. Ohio law prohibits your child from returning to a game or practice on the same day he/she was removed.
4. Be sure that the athletic trainer, coach and physical education teacher are aware of your child's injury and symptoms.
5. Your athlete should complete a step-by-step exercise-based progression, under the direction of a qualified healthcare professional.
6. A sample activity progression is listed below. Generally, each step should take no less than 24 hours so that your child's full recovery would take about one week once they have no symptoms at rest and with moderate exercise.*

Sample Activity Progression*

Step 1: Low levels of non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: walking, light jogging, and easy stationary biking for 20-30 minutes).

Step 2: Moderate, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: moderate jogging, brief sprint running, moderate stationary biking, light calisthenics, and sport-specific drills without contact or collisions for 30-45 minutes).

Step 3: Heavy, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: extensive sprint running, high intensity stationary biking, resistance exercise with machines and free weights, more intense non-contact sports specific drills, agility training and jumping drills for 45-60 minutes).

Step 4: Full contact in controlled practice or scrimmage.

Step 5: Full contact in game play.

*If any symptoms occur, the athlete should drop back to the previous step and try to progress again after a 24 hour rest period.

<http://www.healthy.ohio.gov/vipp/child/returntoplay/concussion>

Ohio Department of Health Concussion Information Sheet

For Interscholastic Athletics

I have read the Ohio Department of Health's Concussion Information Sheet and understand that I have a responsibility to report my/my child's symptoms to coaches, administrators and healthcare provider.

I also understand that I/my child must have no symptoms before return to play can occur.

Athlete

Date

Athlete *Please Print Name*

Parent/Guardian

Date





DEPARTMENT OF ATHLETICS

421 YOCTANGEE PARKWAY
CHILICOTHE, OHIO 45601
(740) 702-2287 x 16249

STUDENT ATHLETE HANDBOOK ACKNOWLEDGMENT FORM 2017-2018

** This statement MUST be signed by the participant and the parent/guardian.

I have read and understand the Chillicothe High School Athletic Department Student Handbook, and I fully understand what is expected of me as a Chillicothe High School program participant. I accept personal responsibility for living up to these expectations, and for abiding by the Athletic Department Student Handbook.

Please Print Student's Name

(Student Signature)

Date

I have read the Chillicothe High School Athletic Department Student Handbook, and I understand what is expected of my son/daughter to live up to the responsibilities and obligations of a Chillicothe High School program participant as outlined.

(Parent/Guardian Signature)

Date

HOME EMAIL ADDRESS: _____

** A copy of this form MUST be on file in the office of the CHS Athletic Director.

Michael Barren, Athletic Director

Monica Hitchens, Secretary


CHILLICOTHE
HIGH SCHOOL
DEPARTMENT OF ATHLETICS
421 YOCTANGEE PARKWAY
CHILLICOTHE, OHIO 45601
(740) 702-2287 x 16249

RESPONSIBILITIES OF PARTICIPANTS IN ATHLETICS
2017-2018

This form will be issued to each participant at Chillicothe High School. The participant will read and sign the form that he/she has received and read. If there are any questions, contact your head coach or CHS Athletic Director William Brown. This form will be kept on file in the athletic department.

1. Due process procedure:

The due process procedure will apply if you have occasion to be removed or suspended from the program as a disciplinary procedure.

2. Accident insurance policy:

All participants must have a minimum of \$5,000 accident insurance coverage. This can be school accident insurance or family accident insurance carried by the family.

3. Equipment responsibility:

All equipment issued by the Athletic Department is school property and must be cared for and returned to the school at the termination of the activity. If equipment is willfully damaged or lost, the participant will be expected to pay a reasonable replacement price.

4. Physical examination requirement:

All participants must have a complete physical examination, as required by the Ohio High School Association, prior to their first practice session. This must be kept on file in the Athletic Office.

I have read and fully understand the above responsibilities.

Athlete's signature	Parent/guardian signature	Date
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Michael Barren, Athletic Director

Monica Hitchens, Secretary



DEPARTMENT OF ATHLETICS

421 YOCTANGEE PARKWAY
CHILLICOTHE, OHIO 45601
(740) 702-2287 x 16249

Players are not required to enroll in these plans, however, we ask that everyone fill out the enclosed form and return it as soon as possible.

If you have any questions, please call the CHS Athletic Office at (740) 702-2287 #16249

NOTE: Make checks payable to: N. Carol Insurance Agency, 1989 W. Fifth Avenue, Suite 6, Columbus, Ohio 43212.

I/We the parent(s)/guardians of _____ have received information regarding insurance for the 2017-18 school year.

PLEASE CHECK ONE:

_____ We already have insurance with _____
Policy# (required) _____ and are not interested in additional coverage.

_____ We already have insurance with _____
but would like to purchase additional insurance under plan number _____.

_____ We have no insurance and wish to purchase insurance under plan _____.

We understand that neither the CHS Athletic Department nor the school assumes any liability for medical claims.

Parent or Guardian signature: _____

Address: _____ Telephone: _____

** If you plan to purchase Plan 1, 2, or 3 or 4 please pick up an insurance form in the Athletic Office.

Michael Barren, Athletic Director

Monica Hitchens, Secretary

EMERGENCY MEDICAL AUTHORIZATION FORM 2017-2018

STUDENT'S NAME _____ BIRTHDATE _____
(Last) (First) (Middle) (Month) (Day) (Year)
ADDRESS _____ PHONE (____) _____

PARENT CELL _____ HOME EMAIL _____

SCHOOL _____ GRADE FOR 2016-2017 BOY _____ GIRL _____

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

FATHER'S NAME _____ OCCUPATION _____

PLACE OF EMPLOYMENT _____ PHONE (____) _____

MOTHER'S NAME _____ OCCUPATION _____

PLACE OF EMPLOYMENT _____ PHONE (____) _____

LEGAL GUARDIAN _____ OCCUPATION _____

PLACE OF EMPLOYMENT _____ PHONE (____) _____

Living with: Parents Mother only Father only Other (specify) _____

Names of relatives or care providers who will assume care if your child becomes ill and neither parent or guardian can be reached.

1. NAME _____ PHONE (____) _____

ADDRESS _____ RELATIONSHIP _____

2. NAME _____ PHONE (____) _____

ADDRESS _____ RELATIONSHIP _____

PART I OR II BE COMPLETED

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____ Phone (____) _____

Dentist _____ Phone (____) _____

Medical Specialist _____ Phone (____) _____

Local Hospital _____ Phone (____) _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Date _____ Signature of Parent/Guardian _____ Address _____

Zip _____ CELL PHONE # _____

PART II: REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Date _____ Signature of Parent/Guardian _____

Address _____ Zip _____ CELL PHONE # _____

Student-Athlete Social Media Agreement and Policy

Social media can be a useful tool to communicate with teammates, fans, friends, coaches, and more. Social media can also be dangerous if you are not careful. There are two types of social media users: those who realize they are functioning in public, and those who don't. Every picture, link, quote, status, tweet, or post that you or your friends put online is forever part of your digital footprint. Content can be captured in screenshots or saved by other users. Keep in mind:

1. Nothing is truly private...ever.
2. If you retweet it (or share it), you own it.
3. Every post/tweet/picture/communication reflects who you are.

You never know when that will come back to hurt or help your reputation during the recruitment process, college admissions, a new job, or other important areas of your life. While we support and encourage individuals' freedom of expression and First Amendment rights, we are concerned about the safety and well-being of our student-athletes. Freedom of speech does not equal freedom from consequences. Inappropriate material affects the perception of our student-athletes, the athletic department, and Chillicothe Schools, students, alumni, and the Chillicothe community.

Recognizing the above: (Please Initial)

- _____ I take responsibility for my online profile, including my posts and any photos, videos or other posts by other in which I appear.
- _____ I will not degrade my opponents before, during, or after games.
- _____ I will post only positive things about my teammates, coaches, opponents, and officials.
- _____ I will use social media to promote abilities, team, community, and social values.
- _____ I will consider how I will be received by others before I post anything.
- _____ I will ignore negative comments about me and will not retaliate.
- _____ If a teammate posts something negative online, I will have a conversation with that teammate. If I do not feel comfortable doing so I will talk to a team captain or coach.
- _____ I am aware that I represent my school, team, family, friends, and community at all times.
- _____ I will not comment on injuries, performances, or other team matters that could reasonably be expected to be confidential to coaches or team members.
- _____ I will abide by all team and athletic department policies, and all OHSAA rules when utilizing social media.
- _____ I will not post information, photos, or other representations of inappropriate behavior (e.g., drug or alcohol use), sexual content, or items that could be interpreted as demeaning, bullying, defamatory, or inflammatory.
- _____ I understand that I will be held responsible by school administration for anything I post.

_____ Upon request, I will provide full access to members of my coaching staff, designated members of the athletic department, and/or the building principal for any and all social media.

_____ If I discover any inappropriate information on any social media of any Chillicothe student-athlete, I will immediately contact one of the following people: the student-athlete, the student-athlete's coach, the captain of the student-athlete's team, the Athletic Director, or the Building Principal.

_____ I understand that violation of this Student-Athlete Social Media Agreement and Policy may result in disciplinary action – including temporary or permanent suspension from the team – as determined by the principal, athletic director and/or head coach.

Best Practices:

1. Live your life, don't tweet your life.
2. Think twice before posting. If you wouldn't want your mom, dad, parents of other students, coach, or future employer to see your post, don't post it.
3. Be respectful and positive. Say thank you to your supporters, and support others.
4. Remember many audiences view your posts including fans, alumni, kids, parents, teachers, and local authorities and community members.
5. The internet is permanent. Even if you delete something, it's still out there somewhere. Be in the right state of mind when you post. Do not post when your judgment is impaired. Coaches and administrators monitor social media. Use the privacy/security settings made available on sites. Be aware of who you add as a friend or allow access to your site.
6. Do not post your email, home address, local address, telephone number, or other personal information (class schedule, social plans) that could lead to unwanted attention, stalking, identity theft, etc.
7. Be respectful, honest, accurate, professional and polite.

Student-Athlete Signature

Parent/Guardian Signature

Date

Student-Athlete
Please Print Name

Parent/Guardian
Please Print Name

Exhibit A (Back Side)

Consent to Perform Urinalysis for Drug Testing

We hereby consent to allow the student-athlete named on the front of this form to undergo urinalysis testing for the presence of illicit drugs or banned substances in accordance with the **Procedure and Procedure for Random Urine Drug Testing of Chillicothe City School District Students** as approved by the Chillicothe City School District Board of Education.

We understand that the collection process will be overseen by a qualified vendor.

We understand that any urine samples will be sent only to a certified medical laboratory for actual testing, and that the samples will be coded to provide confidentiality.

We hereby give our consent to the medical vendor selected by the Chillicothe City School District Board, as well as its laboratory, doctors, employees, or agents, together with any clinic, hospital, or laboratory designated by the selected medical vendor to perform urinalysis testing for the detection of illicit drugs or banned substances.

We further give permission to the medical vendor selected by the Chillicothe City School District Board, as well as its doctors, employees, or agents, to release all results of these tests to the Medical Review Officer (MRO) working for the medical vendor. We understand these results will be forwarded to the Building Principal and will also be made available to us.

We understand that consent pursuant to this **Informed Consent Agreement** will be effective for all athletic activities in which this student-athlete might participate during the current school year.

We hereby release the Chillicothe City School District Board of Education, Testing Provider, and its agents and employees from any legal responsibility or liability, including but not limited to from any and all claims, demands, actions, causes of action, liabilities, controversies, or damages of any kind whatsoever, including expenses and attorneys' fees, whether arising at law or in equity, whether known or unknown, whether direct or contingent, whether liquidated or unliquidated, arising out of, resulting from, or relating to, and which were alleged or could have been alleged with respect to for the release of such information and records.

READ CODE OF CONDUCT AND EXPECTATIONS ON REVERSE SIDE AND SIGN!

Exhibit A

CHILLICOTHE CITY SCHOOL DISTRICT CODE OF CONDUCT AND EXPECTATIONS
INFORMED CONSENT AGREEMENT

Student Name _____ Grade _____
(Please Print)

AS A STUDENT:

- I understand and agree that participation in athletics is a privilege that may be withdrawn for violations of the **Code of Conduct and Expectations**, hereinafter **Code of Conduct**.
- I have read the **Code of Conduct** and thoroughly understand the consequences that I will face if I do not honor my commitment to the **Code of Conduct**.
- I understand and realize that there is risk of injury in participating in athletic activities.
- I understand that when I participate in any athletic program I will be subjected to initial and random urine drug testing, and if I refuse, it will be treated as a positive test. I have read the consent on the reverse of this form and agree to its terms.
- I understand this is binding while a student within the Chillicothe City School District.

Student Signature Date _____

AS A PARENT/GUARDIAN/CUSTODIAN:

- I have read the **Code of Conduct** and understand the responsibilities of my son/daughter/ward as a participant in athletics in the Chillicothe City School District.
- I understand and realize that there is an assumed risk of injury involved for my son/daughter/ward as a participant in athletic activities.
- I understand that if my son/daughter/ward has finished his/her athletic activity and does not intend to participate in any other athletic activities for the remainder of the school year, I can remove him/her from this program with a signed letter to the designated official. If no letter is submitted, then the student-athlete will remain in the program for the remainder of the school year.
- I understand that my son/daughter/ward, when participating in athletics, may be subjected to initial and random urine drug testing, and if he/she refuses, he/she will not be allowed to practice or participate. I have read the consent on the reverse of this form and agree to its terms.
- I understand this is binding while my son/daughter/ward is a student within the Chillicothe City School District.

Parent/Guardian/Custodian Signature Date _____

Parent/Guardian/Custodian Name (print) Home Phone Work Phone

ASSUMPTION OF RISK
AND
RELEASE OF ALL CLAIMS

As a parent/guardian of a child wishing to participate in athletic activities and/or other activities taking place in the buildings of or upon the grounds of the Chillicothe City School District, I recognize and acknowledge that all such activities carry a certain risk of personal injury. I agree, on behalf of myself and my child, to assume all such risks including any damages resulting from physical injuries, death, loss of services or consortium, loss of damage to property, or any other loss which I or my child may sustain as a result of participating in any such activities.

I hereby give permission for my child (as named below) to participate in the activity named below and any related events, activities, or transportation. In consideration of allowing my child's participation in the activity or activities indicated below, I hereby, for myself, for my child, and for all heirs, executors, administrators, and assigns, do hereby forever release, waive, and relinquish all claims I or my child have or may have against the Chillicothe City School District or any of its personnel as a result of participating in this and any other programs which are permitted to conduct activities in the buildings and/or grounds of the Chillicothe City School District. Furthermore, I promise on behalf of myself and my child not to sue the Chillicothe City School District Board of Education or any of its officers, employees, or agents for actions or omissions arising from or connected with such activities, and to indemnify and hold the Chillicothe City School District Board of Education harmless from any loss or damages incurred by the Chillicothe City School District Board of Education as a consequence of my or my child's participation in such activities.

ACTIVITY: _____

NAME OF STUDENT: _____

SIGNATURE OF PARENT / GUARDIAN*

SIGNATURE OF PARENT / GUARDIAN*

DATE

*Both parents must sign unless only one has legal custody.

