



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.

Table with columns: GENERAL QUESTIONS, HEART HEALTH QUESTIONS ABOUT YOU, HEART HEALTH QUESTIONS ABOUT YOUR FAMILY, BONE AND JOINT QUESTIONS. Includes questions 1-21.

Table with columns: BONE AND JOINT QUESTIONS - CONTINUED. Includes questions 22-25.

Table with columns: MEDICAL QUESTIONS, FEMALES ONLY. Includes questions 26-54.

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: _____



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
Sex Age Grade School Date of birth Sport(s)

Table with 16 rows of questions and Yes/No columns. Questions include: 1. Type of disability, 2. Date of disability, 3. Classification, 4. Cause of disability, 5. List the sports you are interested in playing, 6-16. Do you regularly use a brace, assistive device or prosthetic? Do you use a special brace or assistive device for sports? Do you have any rashes, pressure sores, or any other skin problems? Do you have a hearing loss? Do you use a hearing aid? Do you have a visual impairment? Do you have any special devices for bowel or bladder function? Do you have burning or discomfort when urinating? Have you had autonomic dysreflexia? Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia) illness? Do you have muscle spasticity? 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.

Table with 16 rows of conditions and Yes/No columns. Conditions include: 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).

Table with columns: EXAMINATION, DATE OF EXAMINATION, and sub-columns for NORMAL and ABNORMAL FINDINGS. Rows include: Height, Weight, BP, Pulse, Vision, L20, Corrected, MEDICAL (Appearance, Eyes/ears/nose/throat, Lymph nodes, Heart, Pulses, Lungs, Abdomen, Genitourinary, Skin, Neurologic), MUSCULOSKELETAL (Neck, Back, Shoulder/arm, Elbow/forearm, Wrist/hand/fingers, Hip/thigh, Knee, Leg/ankle, Foot/toes, Functional).

*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.

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 _____
