

OSSAA PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM

PLEASE PRINT

DATE OF EXAM _____

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal physician _____ Phone _____

In case of emergency, contact: Name _____

Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers below. Circle questions you don't know the answers to.

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|----------------------------------|------------------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing or chronic illness? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Do you cough, wheeze, or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you or does someone in your family have sickle cell trait or disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 32. Do you wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 33. Have you ever had a sprain, strain, or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 34. Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | 36. If yes, check appropriate box and explain below. | | |
| 14. Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| 15. Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| 16. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| 17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/calf |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| 19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper arm | | <input type="checkbox"/> Foot |
| 20. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | 37. Do you want to weigh more or less than you do now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | 38. Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 40. Record the dates of your most recent immunizations (shots) for: | | |
| | | | Tetanus _____ Measles _____ | | |
| | | | Hepatitis _____ Chickenpox _____ | | |

Explain "Yes" answers on a separate sheet.

The above information is correct to the best of my knowledge. I hereby give my informed consent for the above-mentioned student to participate in activities. I understand the risk of injury in athletic participation. If my son/daughter becomes ill or is injured, necessary medical care can be instituted by physicians, coaches, athletic trainers or other personnel properly trained. I further acknowledge and consent that, as a condition for participating in activities, identifying information about the above-mentioned student may be disclosed to OSSAA in connection with any investigation or inquiry concerning the student's eligibility to participate and/or any possible violation of OSSAA rules. OSSAA will undertake reasonable measure to maintain the confidentiality of such identifying information, provided that such information has not otherwise been publicly disclosed in some manner.

Signature of parent/guardian _____ Signature of Athlete _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION

PLEASE PRINT

DATE OF EXAM _____

Name _____ Date of Birth _____

Height _____ Weight _____ Body fat (optional) _____ % Pulse _____ BP _____ / _____ Color Blind Yes No (circle one)

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

| MEDICAL | Normal | Abnormal Findings |
|-----------------------|--------|-------------------|
| Appearance | | |
| Eyes/Ears/Throat | | |
| Lymph Nodes | | |
| Heart | | |
| Pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitalia (male only) | | |
| Skin | | |
| MUSCULOSKELETAL | | |
| Neck | | |
| Back | | |
| Shoulder/Arm | | |
| Elbow/Forearm | | |
| Wrist/Hand | | |
| Hip/Thigh | | |
| Knee | | |
| Leg/Ankle | | |
| Foot | | |

CLEARANCE

() Cleared

() Cleared after completing evaluation/rehabilitation for: _____

() Not cleared for: _____ Reason: _____

Recommendations: _____

Name & Title of Examiner (Print/Type) _____ Date _____

Address _____ Phone _____

Signature of Examiner _____

Authorization for Medical Care of a Minor

I, _____,
Parent/Guardian Name (PLEASE PRINT)

the undersigned parent or person having legal custody or the legal guardian of:

Name of Student

DO HEREBY AUTHORIZE any agent of the Haileyville Public Schools to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon the advice of a physician, surgeon or dentist licensed under the laws of the State of Oklahoma.

IN GIVING THIS CONSENT, I RECOGNIZE AND UNDERSTAND that in situations where the above named minor requires immediate medical or hospital care it may not be possible to contact me and that in such situations I will not be able to knowledgeably evaluate and choose among the available alternative treatments or procedures, if any, or to evaluate the risks attendant upon each, and the risks attendant to foregoing all treatment. In such situations, I authorize a physician, surgeon or dentist to exercise his/her professional judgment and assess the risks incident and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he/she in his/her professional judgment determines to be necessary for the health or safety of the above named minor.

Treatment Information

Minor's Date of Birth _____

Physician Name _____ Phone # _____

Allergies _____

Medication taken regularly _____

Medical History (surgeries, illnesses, ect.) _____

Parent/Guardian Signature _____ Date _____

Primary phone number _____



Oklahoma State Department of Health
Creating a State of Health



Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs

Haileyville
(NAME OF SCHOOL)

I have reviewed the Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms (SCA) and Warning Signs informational material jointly developed by Oklahoma State Department of Health and the Oklahoma State Department of Education and understand the symptoms and warning signs of SCA related to participation in athletic programs.

Signature of Student-Athlete

Print Student-Athlete's Name

Date

Signature of Parent/Guardian

Print Parent/Guardian's Name

Date

This form is required to be completed annually prior to the athlete's first practice and/or competition and be kept on file for one year beyond the date of signature in the principal's office or the office designated by the principal.