

**OHIO HIGH SCHOOL ATHLETIC ASSOCIATION
STUDENT PARTICIPATION AND PHYSICAL EXAM FORM**

PLEASE TYPE OR PRINT:

STUDENT'S NAME _____ BIRTH DATE _____ SEX _____ GRADE _____

CITY _____ LAST _____ FIRST _____ M.I. _____ 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, ADDRESS, 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 CONCIIOUSNESS 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)