

PREPARTICIPATION PHYSICAL EVALUATION | OHIO HIGH SCHOOL ATHLETIC ASSOCIATION | 2024-25

HISTORY FORM

Note: Complete and sign this form (with your parents				
Name:		Date	e of birth:	
Date of examination:	Sport(s):			
Sex assigned at birth (F, M, or intersex):	How do you ident	ify your gender? (F,	M, non-binary, or anoth	her gender):
List past and current medical conditions.				
Have you ever had surgery? If yes, list all past surgical	procedures.			
Medicines and supplements: List all current prescription	ons, over-the-cou	nter medicines, and	I supplements (herbal a	nd nutritional).
Do you have any allergies? If yes, please list all your	allergies (ie. me	dicines, pollens, for	od, stinging insects).	
Patient Health Questionnaire Version 4 (PHQ-4)				
Over the last 2 weeks, how often have you been bot	hered by any of	the following probl	ems? (Circle response.)	
	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1 -	2	3
(A sum of ≥3 is considered positive on either so	ubscale (question	ns 1 and 2, or ques	tions 3 and 4] for scree	ning purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
Do you have any concerns that you would like to discuss with your provider?		
Has a provider ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
Have you ever passed out or nearly passed out during or after exercise?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		2.1
Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

	ART HEALTH QUESTIONS ABOUT YOU ONTINUED)		Yes	No
9.	. Do you get light-headed or feel shorter of breat than your friends during exercise?	h		
10. Have you ever had a seizure?				
НЕА	RT HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	Yes	No
11.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12.	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13.	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No	MEDICAL QUESTIONS (CONTINUED)	Yes	
14. Have you ever had a stress fracture or an injury to a			25. Do you worry about your weight?		
bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			26. Are you trying to or has anyone recommended that you gain or lose weight?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. Are you on a special diet or do you avoid certain types of foods or food groups?		
MEDICAL QUESTIONS	Yes	No	28. Have you ever had an eating disorder?		L
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?			MENSTRUAL QUESTIONS N/A 29. Have you ever had a menstrual period?	Yes	F
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?			30. How old were you when you had your first menstrual period?		٠.
18. Do you have groin or testicle pain or a painful bulge			31. When was your most recent menstrual period?		_
or hernia in the groin area?		l	32. How many periods have you had in the past 12		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			months? Explain "Yes" answers here.		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?					
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?					_
22. Have you ever become ill while exercising in the heat?					_
23. Do you or does someone in your family have sickle cell trait or disease?				-	_
24. Have you ever had or do you have any problems					

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Signature of parent or guardian:



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ame:		Date	of Birth: ———		Grade	e in School: ———
HYSICIAN REMINE	neps					
		citivo issuos				
	nal questions on more-sen					
	ressed out or under a lot					
	eel sad, hopeless, depress					
Do you feel sa	afe at your home or reside	encer ****	f or din?			
Have you eve	r tried digarettes, e-digare	ttes, chewing tobacco, snuf	din?			
		chewing tobacco, snuff, or	uip.			
Do you drink	alcohol or use any other	or used any other performa	nce-enhancing s	supplemen	it?	
Have you eve	r taken anabolic steroius t	to help you gain or lose wei	ght or improve	vour perfo	rmance?	
Have you eve	a seat belt, use a helmet,	and use condoms?	gire or improve	,		
 Do you wear a Consider reviewing 	ing questions on cardiova	ascular symptoms (Q4–Q13	of History For	m).		
EXAMINATION						
Height:	Weight:					
BP: / (/) Pulse:	Vision: R 20/	L 20/	Correct	ted: □Y	
MEDICAL					NORMAL	ABNORMAL FINDING
Appearance						
Marfan stigmata (k	kyphoscoliosis, high-arched p	palate, pectus excavatum, arac	hnodactyly, hype	rlaxity,		
myopia, mitral valv	ve prolapse [MVP], and aorti	c insufficiency)				
						1
Eyes, ears, nose, and t						
Eyes, ears, nose, and t • Pupils equal						
• Pupils equal						
Pupils equal Hearing Lymph nodes Heart*	throat					
Pupils equal Hearing Lymph nodes Heart*	throat	upine, and ± Valsalva maneuve	.)			
Pupils equal Hearing Lymph nodes Heart*	throat		•)			
 Pupils equal Hearing Lymph nodes Heart^a Murmurs (auscultat 	throat		•)			
Pupils equal Hearing Lymph nodes Hearta Murmurs (auscultat Lungs Abdomen	throat tion standing, auscultation su	upine, and ± Valsalva maneuver				
Pupils equal Hearing Lymph nodes Hearta Murmurs (auscultat Lungs Abdomen	throat tion standing, auscultation su			:A), or		
Pupils equal Hearing Lymph nodes Hearta Murmurs (auscultat Lungs Abdomen	throat tion standing, auscultation su	upine, and ± Valsalva maneuver		:A), or		
Pupils equal Hearing Lymph nodes Heart Murmurs (auscultat Lungs Abdomen Skin Herpes simplex viru	throat tion standing, auscultation su	upine, and ± Valsalva maneuver		SA), or		
Pupils equal Hearing Lymph nodes Hearta Murmurs (auscultat Lungs Abdomen Skin Herpes simplex viru tinea corporis	throat tion standing, auscultation su	upine, and ± Valsalva maneuver		SA), or	NORMAL	ABNORMAL FINDING
Pupils equal Hearing Lymph nodes Heart* Murmurs (auscultat Lungs Abdomen Skin Herpes simplex viru tinea corporis Neurological	throat tion standing, auscultation su	upine, and ± Valsalva maneuver		SA), or	NORMAL	ABNORMAL FINDING
Pupils equal Hearing Lymph nodes Heart Murmurs (auscultat Lungs Abdomen Skin Herpes simplex viru tinea corporis Neurological MUSCULOSKELETAL Neck	throat tion standing, auscultation su	upine, and ± Valsalva maneuver		(A), or	NORMAL	ABNORMAL FINDING
Pupils equal Hearing Lymph nodes Hearta Murmurs (auscultat Lungs Abdomen Skin Herpes simplex viru tinea corporis Neurological MUSCULOSKELETAL Neck Back	throat tion standing, auscultation su	upine, and ± Valsalva maneuver		iA), or	NORMAL	ABNORMAL FINDING
Pupils equal Hearing Lymph nodes Hearta Murmurs (auscultat Lungs Abdomen Skin Herpes simplex viru tinea corporis Neurological MUSCULOSKELETAL Neck Back Shoulder and arm	throat tion standing, auscultation su	upine, and ± Valsalva maneuver		SA), or	NORMAL	ABNORMAL FINDING
Pupils equal Hearing Lymph nodes Heart* Murmurs (auscultat Lungs Abdomen Skin Herpes simplex viru tinea corporis Neurological MUSCULOSKELETAL Neck Back Shoulder and arm Elbow and forearm	tion standing, auscultation su us (HSV), lesions suggestive of	upine, and ± Valsalva maneuver		iA), or	NORMAL	ABNORMAL FINDING
Pupils equal Hearing Lymph nodes Hearta Murmurs (auscultate Lungs Abdomen Skin Herpes simplex viruatinea corporis Neurological MUSCULOSKELETAL Neck Back Shoulder and arm Elbow and forearm Wrist, hand, and finge	tion standing, auscultation su us (HSV), lesions suggestive of	upine, and ± Valsalva maneuver		iA), or	NORMAL	ABNORMAL FINDING
Pupils equal Hearing Lymph nodes Hearta Murmurs (auscultat Lungs Abdomen Skin Herpes simplex viru tinea corporis Neurological MUSCULOSKELETAL Neck Back Shoulder and arm Elbow and forearm Wrist, hand, and finge	tion standing, auscultation su us (HSV), lesions suggestive of	upine, and ± Valsalva maneuver		iA), or	NORMAL	ABNORMAL FINDING
Pupils equal Hearing Lymph nodes Heart* Murmurs (auscultat Lungs Abdomen Skin Herpes simplex viru tinea corporis Neurological MUSCULOSKELETAL Neck Back Shoulder and arm Elbow and forearm Wrist, hand, and finge. Hip and thigh Knee	tion standing, auscultation su us (HSV), lesions suggestive of	upine, and ± Valsalva maneuver		iA), or	NORMAL	ABNORMAL FINDING
Pupils equal Hearing Lymph nodes Heart* Murmurs (auscultated Lungs Abdomen Skin Herpes simplex viruatinea corporis Neurological MUSCULOSKELETAL Neck Back Shoulder and arm Elbow and forearm Wrist, hand, and finged Hip and thigh Knee Leg and ankle	tion standing, auscultation su us (HSV), lesions suggestive of	upine, and ± Valsalva maneuver		SA), or	NORMAL	ABNORMAL FINDING
Pupils equal Hearing Lymph nodes Hearta Murmurs (auscultate Lungs Abdomen Skin Herpes simplex viruatinea corporis Neurological MUSCULOSKELETAL Neck Back Shoulder and arm Elbow and forearm Wrist, hand, and finger Hip and thigh Knee Leg and ankle Foot and toes	tion standing, auscultation su us (HSV), lesions suggestive of	upine, and ± Valsalva maneuver		SA), or	NORMAL	ABNORMAL FINDING
Pupils equal Hearing Lymph nodes Heart Murmurs (auscultat Lungs Abdomen Skin Herpes simplex viru tinea corporis Neurological MUSCULOSKELETAL Neck Back Shoulder and arm Elbow and forearm Wrist, hand, and finge. Hip and thigh Knee Leg and ankle Foot and toes Functional	tion standing, auscultation su us (HSV), lesions suggestive of	upine, and ± Valsalva maneuve		iA), or	NORMAL	ABNORMAL FINDING
Pupils equal Hearing Lymph nodes Heart* Murmurs (auscultated Lungs Abdomen Skin Herpes simplex viruatinea corporis Neurological MUSCULOSKELETAL Neck Back Shoulder and arm Elbow and forearm Wrist, hand, and finged Hip and thigh Knee Leg and ankle Foot and toes Functional Double-leg squat tee	tion standing, auscultation su us (HSV), lesions suggestive of rs	upine, and ± Valsalva maneuve	occus aureus (MRS			

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MD, DO, DC, NP, or PA

Address:_

Signature of health care professional:_



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MEDICAL ELIGIBILITY FORM Name: ____ ______ Date of Birth: ______ Grade in School: _____ ☐ Medically eligible for all sports without restriction Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of ☐ Medically eligible for certain sports ☐ Not medically eligible pending further evaluation □ Not medically eligible for any sports Recommendations: ___ I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form, A copy of the physical examination findings is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians). Name of health care professional (print or type): _____ Date of Exam:____ Address: ______ Phone: ____ Signature of health care professional:____ SHARED EMERGENCY INFORMATION Allergies: _ Medications: ___ Other information: ____ Emergency contacts:

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ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Date of birth:		
Name:Date of birtii		
1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
5. List the sports you are playing.	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 use 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 as having 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:		
explain tes answers here.		
Please indicate whether you have ever had any of the following conditions:		
	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding	-	
Enlarged spleen	\dashv	
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		\vdash
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 questions on this form are complete an	d correct.	
Signature of athlete:		
Signature of parent or guardian:		
Date:		
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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 | 2024 - 2025

I hereby authorize the release and disclosure of the personal health information of ("School").	("Student"), as described below, to
The information described below may be released to the School principal or assista teacher, school nurse or other member of the School's administrative staff as necessactivities, including but not limited to interscholastic sports programs, physical educations and the school of the	sary to evaluate the Student's eligibility to participate in school sponsored
Personal health information of the Student which may be released and disclosed in Student's eligibility to participate in school sponsored activities, including but not liverequired by the School prior to determining eligibility of the Student to participate evaluation, diagnosis and treatment of injuries which the Student incurred while er sessions, training and competition; and other records as necessary to determine the	nited to the Pre-participation Evaluation form or other similar document in classroom or other School sponsored activities; records of the gaging in school sponsored activities, including but not limited to practice
The personal health information described above may be released or disclosed to to ther health care professional retained by the School to perform physical examinat sponsored activities or to provide treatment to students injured while participating professionals are paid for their services or volunteer their time to the School; or an evaluates, diagnoses or treats an injury or other condition incurred by the students	ions to determine the Student's eligibility to participate in certain school in such activities, whether or not such physicians or other health care y other EMT, hospital, physician or other health care professional who
I understand that the School has requested this authorization to release or disclose decisions about the Student's health and ability to participate in certain school sporprovider or health plan covered by federal HIPAA privacy regulations, and the inforprotected by the federal HIPAA privacy regulations. I also understand that the School educational records, and that the personal health information disclosed under this	nsored and classroom activities, and that the School is a not a health care mation described below may be redisclosed and may not continue to be pool is covered under the federal regulations that govern the privacy of
I also understand that health care providers and health plans may not condition the however, the Student's participation in certain school sponsored activities may be	e provision of treatment or payment on the signing of this authorization; conditioned on the signing of this authorization.
I understand that I may revoke this authorization in writing at any time, except to to on this authorization, by sending a written revocation to the school principal (or details).	
Name of Principal:	
School Address:	
This authorization will expire when the student is no longer enrolled as a student a	t the school.
NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHOR	
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 (document)	mentation must be provided)
Signature of Student's personal representative, if applicable	Date