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
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
	Do you have an ongoing or chronic illness?	☐	☐
2.	Have you ever been hospitalized overnight?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
	Have you ever had a rash or hives develop during or after exercise?	☐	☐
5.	Have you ever passed out during or after exercise?	☐	☐
	Have you ever been dizzy during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
8.	Have you ever become ill from exercising in the heat?	☐	☐

		YES	NO
9.	Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
10.	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)?	☐	☐
11.	Have you had any problems with your eyes or vision?	☐	☐
	Do you wear glasses, contacts, or protective eyewear?	☐	☐
12.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

If yes, check appropriate box and explain below.

☐ **Head**	☐ **Elbow**	☐ **Hip**
☐ **Neck**	☐ **Forearm**	☐ **Thigh**
☐ **Back**	☐ **Wrist**	☐ **Knee**
☐ **Chest**	☐ **Hand**	☐ **Shin/calf**
☐ **Shoulder**	☐ **Finger**	☐ **Ankle**
☐ **Upper arm**		☐ **Foot**

13.	Do you want to weigh more or less than you do now?	☐	☐
	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14.	Do you feel stressed out?	☐	☐

15. Record the dates of your most recent immunizations (shots) for:
Tetanus_____ Measles _____
Hepatitis_____ Chickenpox _____

Explain "Yes" answers here: _____

_____

_____

_____

_____

_____

_____

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, trainers or other personnel properly trained.

Signature of parent/guardian _____ Date_____

Signature of athlete _____

(Complete Back Side)

PREPARTICIPATION PHYSICAL EVALUATION

PLEASE PRINT DATE OF EXAM _____

Name _____ Date of Birth _____

Height _____ Weight _____ Body fat (optional) _____% Pulse_____ BP _____/_____ (_____/_____, _____/_____)
Initial BP Post Exercise 5 Min. Post Ex.

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		
MUSCULOSKETAL		
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 _____