For all 6th, 7th, and 8th Graders...

Findlay Middle School Mass Physicals Date: Tuesday May 21st

Time: 5:00

Location: Blanchard Valley Medical Associates 200 West Pearl St.

Cost: \$10

Physical form medical history and preinformation must be filled out in advance or no physical will be given.

Packets can be picked up in the main office.



Ohio High School Athletic Association



PREPARTICIPATION PHYSICAL EVALUATION March 2013-June 2014

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	orm is to be filled out by the student and parent prior to seeing th	ne medical examiner.	The medical examiner should keep this form in the chart,)		
			•		
			Date of birth	-	
	Age Grade School			-	
			Relationship	•	
			(Email)	***************************************	
	and Allergies: Please list the prescription and over-the-counte		plements (herbal and nutritional-including energy drinks/ protein supplements) that you are	re	4
Do you hay	re any allergies? Yes No If yes, please identify specifi	c allerov helow			
☐ Medic		Food	T 05-1-1-1-1		
·	es" answers below. Circle questions you don't know		Stinging Insects		_
1. Has a reaso	a doctor ever denied or restricted your participation in sports for any on? Du have any ongoing medical conditions? If so, please identify or. Asthma Anemia Diabetes Infections	Yes No	BONE AND JOINT QUESTIONS CONTINUED 22. Do you regularly use a brace, orthotics, or other assistive device? 23. Do you have a bone, muscle, or joint injury that bothers you? 24. Do any of your joints become painful, swolllen, teel warm, or look red? 25. Do you have any history of juvenile arthritis or connective tissue disease?	Yes	No
	you ever spent the night in the hospital?		MEDIGAL QUESTIONS	Yes	No
	you ever had surgery? ALTH QUESTIONS ABOUT YOU	arat da arat d	Do you cough, wheeze, or have difficulty breathing during or after exercise? Have you ever used an inhaler or taken asthma medicine?		ļ
	you ever passed out or nearly passed out DURING or AFTER	es seco	Have you ever used an inhaler or taken asthma medicine? Is there anyone in your family who has asthma?	 	
exerc			29. Were you born without or are you missing a kidney, an eye, a testicle (males),		
	you ever had discomfort, pain, lightness, or pressure in your chest q exercise?		your spleen, or any other organ? 30. Do you have groin pain or a painful buige or hemia in the groin area?	ļ	·
	your heart ever race or skip beats (irregular beats) during exercise	7	31. Have you had infectious mononucleosis (mono) within the past month?		
	a doctor ever told you that you have any heart problems? If so, chec	k	32. Do you have any rashes, pressure sores, or other skin problems?		
	at apply: High blood pressure A heart murmur		33. Have you had a herpes (cold sores) or MRSA (staph) skin infection? 34. Have you ever had a head injury or concussion?		<u> </u>
	High cholesterol A heart infection		Have you ever had a head injury or concussion? Have you ever had a hit or blow to the head that caused confusion,		†
	Kawasaki disease Other:		prolonged headaches, or memory problems?		1
	a doctor ever ordered a test for your heart? (For example, ECG/EKG	à,	36. Do you have a history of seizure disorder or epilepsy?		1
10. Do y	cardiogram) ou get lightheaded or feel more short of breath than expected during		Do you have neadaches with exercise? Have you ever had numbness, tingling, or weakness in your arms or		
exert			legs after being hit or falling?		
	by you ever had an unexplained seizure? Ou get more tired or short of breath more quickly than your friends		 Have you ever been unable to move your arms or legs after being hit or falling? Have you ever become it white exercising in the heat? 		4
	g exercise?	and the second	41. Do you get frequent muscle cramps when exercising?		-
	AUTH QUESTIONS ABOUT YOUR FAMILY	Yes No	42. Do you or someone in your family have sickle cell trait or disease?		
	any family member or relative died of heart problems or had an pected or unexplained sudden death before age 50 (including		43. Have you had any problems with your eyes or vision? 44. Have you had an eye injury?		
	ning, unexplained car accident, or sudden infant death syndrome)?		45. Do you wear glasses or contact tenses?	<u> </u>	+
	anyone in your family have hypertrophic cardiomyopathy, Marian		46. Do you wear protective eyewear, such as goggles or a face shield?		
	rome, arryhthmogenic right ventricular cardiomyopathy, iong QT rome, short QT syndrome, Brugada syndrome, or catechoiaminergic		Do you worry about your weight? 48. Are you trying to gain or lose weight? Has anyone recommended that you do?		
	norphic ventricular tachycardia?		49. Are you on a special diet or do you avoid certain types of foods?	 	+
	anyone in your family have a heart problem, pacemaker, or implant	ed	50. Have you ever had an eating disorder?		1
	rillator? enyone in your family had unexplained fainting, unexplained seizure	-	51. Do you have any concerns that you would like to discuss with a doctor? FEMALES ONLY		i ventomin
	ar drowning?	91	52. Have you ever had a menstrual period?	APPENDED	CALLS STATE
17. Have	JOINT QUESTIONS you ever had an injury to a bone, muscle, ligament, or tendon that ed you to miss a practice or game?	Yes No	53. How old were you when you had your first menstrual period? 54. How many periods have you had in the last 12 months?		
19. Have	you ever had any broken or fractured bones or dislocated joints? you ever had an injury that required x-rays, MRI, CT scan, injection py, a brace, a cast, or crutches?	ıs,	Explain "yes" answers here	····	
20. Have	you ever had a stress fracture?	-			
21. Have	you ever been told that you have or have you had an x-ray for neck bility or atlantoaxial instability? (Down syndrome or dwarfism)	and the same of			
···					
hereby stat Signature of St	te that, to the best of my knowledge, my answers to the aboutent Signat Ves No. 15 to 25	ure of parent/guardian_	omplete and correct. Date:		



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PREPARTICIPATION PHYSICAL EVALUATION March 2013-June 2014 THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

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ame	Make of hinte
x Age Grade School	Date of birth
Type of disability	
Date of disability	
3. Classification (if available)	
4. Cause of disability (birth, disease, accident/trauma, other)	
List the sports you are interested in playing	
	Yes No
6. 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?	
2. Do you have burning or discomfort when urinating?	
3. Have you had autonomic dysreflexia?	
4. Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hyperthermia)	othermia) iliness?
Do you have muscle spasticity?	
5. Do you have frequent seizures that cannot be controlled by medication?	
xplain "yes" answers here	
	aves No.
tlantoaxial instability	Yes No.
tlantoaxial instability	Wes No.
tlantoaxial instability -ray evaluation for atlantoaxial instability	Yes No
tlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one)	Yes No
tlantoaxial instability -ray evaluation for atlantoaxial instability bislocated joints (more than one) asy bleeding	Yes No.
dantoaxial instability -ray evaluation for atlantoaxial instability bislocated joints (more than one) casy bleeding intarged spieen	Yes No.
Adantoaxial instability Aray evaluation for atlantoaxial instability Dislocated joints (more than one) Lasy bleeding Inlarged spieen Iepatitis	No.
Atlantoaxial instability A-ray evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spieen Repatitis Instability	No.
Adantoaxial instability Aray evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Inlarged spieen Idepatitis Disteopenia or osteoporosis Ifficulty controlling bowel	No.
Atlantoaxial instability A-ray evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spieen Repatitis Dislocated joints or osteoporosis Difficulty controlling bowel Difficulty controlling biadder	No.
Atlantoaxial instability K-ray evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spieen Repatitis Disteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling biadder Rumbness or bingling in arms or hands	Mes No.
Atlantoaxial instability K-ray evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spieen Hepatitis Deteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling biadder Iumbness or tingling in arms or hands Iumbness or tingling in legs or feet	No.
lease indicate if you have ever had any of the following. Adantoaxial instability Aray evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spieen Hepatitis Disteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling biadder Humbness or tingling in arms or hands Jumbness or tingling in legs or feet Veakness in arms or hands	No.
Atlantoaxial instability Array evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spieen Repatitis Descopenia or osteoporosis Difficulty controlling bowel Difficulty controlling biadder Rumbness or tingling in arms or hands Rumbness or tingling in legs or feet Veakness in arms or hands Veakness in legs or feet	Nes No
Atlantoaxial instability Aray evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spieen Idepatitis Disteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling biadder Tumbness or tingling in arms or hands Tumbness or tingling in legs or feet Veakness in arms or hands Veakness in legs or feet ecent change in coordination	No.
Atlantoaxial instability Atlantoaxial instability Aray evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spieen depatitis Disteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder fumbness or tingling in arms or hands fumbness or tingling in legs or feet Veakness in arms or hands Veakness in legs or feet decent change in coordination decent change in ability to walk	Nes No
Atlantoaxial instability Aray evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spieen Repatitis Sisteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling biadder Rumbness or tingling in arms or hands Rumbness or fingling in legs or feet Veakness in arms or hands Veakness in legs or feet Recent change in coordination Recent change in ability to walk Pina bifida	Yes = No
Atlantoaxial instability Array evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spieen Repatitis Disteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling biadder Rumbness or tingling in arms or hands Rumbness or tingling in legs or feet Veakness in arms or hands	Nes No



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1 1 1 O I O I C TANGET I I O I 4 I O I 6 I BI	
Name	Date of birth
PHYSICIAN REMINDERS	
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).

EXAMINATION							
Height		Weight		□ Male	☐ Female		and the second s
BP /	(/). Pulse	Vision R 20/	L20/	Con	rected 🗆 Y	′ 🗆 N
#MEDICAL				NO	RMAL	(IABNORMAL)	INDINGS 11 11 11
Appearance							
Marfan stigmata (kyphoso			ım, arachnodactyly,				
arm span > height, hyperia	ixity, myopia, MVF	, aortic insufficiency)					
Eyes/ears/nose/throat							
Pupils equal			•				
Hearing				-			
Lymph nodes							
Heart							
Murmurs (auscultation sta		•					
Location of the point of ma	aximal impulse (Pl	MI)					
Pulses							
Simultaneous femoral and	radial pulses						
Lungs							
Abdomen							
Genitourinary (males only)							
Skin					-		
HSV, lesions suggesting	ve of MRSA, tine	a corporis					
Neurologic							
MUSCULOSKEEETAL			Carry a a repor	enas į	gand rate con		uğuği Erzeni güğ
Neck							
Back							
Shoulder/arm							
Elbow/forearm							
Wrist/hand/fingers							***************************************
Hip/thigh							
Knee							
Leg/ankie							***************************************
Foot/toes							
Functional							
Duck walk, single leg h	юр						

^aConsider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third part present is recommended.

Consider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

PREPARTICIPATION PHYSICAL EVALUATION March 2013-June 2014

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CLEARANCE FORM

Note: Authorization forms (pages 5 and 6) must be signed by both the parent/quardian and the student.

Name ______ Sex D M D 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 _____ Recommendations I have examined the above-named student and completed the preparticipation 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). Phone ______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 Other Information _____

THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHÖLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL



OHSAA AUTHORIZATION FORM 2013-2014

Signature of Student's personal representative, if applicable	Date
I am the Student's (check one): Parent Legal Guardian (document of the Student's (check one): Parent Legal Guardian (document of the Student's (check one): Parent Legal Guardian (document of the Student's (check one): Parent Legal Guardian (document of the Student's (check one): Parent Legal Guardian (document of the Student's (check one): Parent Legal Guardian (document of the Student's (check one): Parent Legal Guardian (document of the Student's (check one): Parent Legal Guardian (document of the Student's (check one): Parent Legal Guardian (document of the Student of the	mentation must be provided)
Name of Student's personal representative, if applicable	
Student's Signature	Birth date of Student, including year
NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THE	IS AUTHORIZATION PERSONALLY.
This authorization will expire when the student is no longer enrolled as a student at the	
School Address:	
Name of Principal:	
I understand that I may revoke this authorization in writing at any time, except to the authorization, by sending a written revocation to the school principal (or designee) when the school principal is the school principal in the school principal in the school principal is the school principal in the school principal in the school principal is the school principal in the school principal	extent that action has been taken by a health care provider in reliance on this nose name and address appears below.
I also understand that health care providers and health plans may not condition the p the Student's participation in certain school sponsored activities may be conditioned	on the signing of this authorization.
I understand that the School has requested this authorization to release or disclose the Student's health and ability to participate in certain school sponsored and classrocovered by federal HIPAA privacy regulations, and the information described below no privacy regulations. I also understand that the School is covered under the federal respectively information disclosed under this authorization may be protected by those regulations.	om activities, and that the School is a not a health care provider or health plan hay be redisclosed and may not continue to be protected by the federal HIPAA igulations that govern the privacy of educational records, and that the personal lations.
The personal health information described above may be released or disclosed to the health care professional retained by the School to perform physical examinations to d activities or to provide treatment to students injured while participating in such activitie their services or volunteer their time to the School; or any other EMT, hospital, physic injury or other condition incurred by the student while participating in school sponsore	letermine the Student's eligibility to participate in certain school sponsored as, whether or not such physicians or other health care professionals are paid for ian or other health care professional who evaluates, diagnoses or treats an
Personal health information of the Student which may be released and disclosed including billity to participate in school sponsored activities, including but not limited to the PSChool prior to determining eligibility of the Student to participate in classroom or other treatment of injuries which the Student incurred while engaging in school sponsored and other records as necessary to determine the Student's physical fitness to participate.	Pre-participation Evaluation form or other similar document required by the er School sponsored activities; records of the evaluation, diagnosis and activities, including but not limited to practice sessions, training and competition;
The information described below may be released to the School principal or assistant school nurse or other member of the School's administrative staff as necessary to evaluating but not limited to interscholastic sports programs, physical education classes	aluate the Student's eligibility to participate in school sponsored activities.
hereby authorize the release and disclosure of the personal health information of("School").	("Student"), as described below, to

2013-2014 Ohio High School Athletic Association Eligibility and Authorization Statement

This document is to be signed by the participant from an OHSAA member school and by the participant's parent.

I have read, understand and acknowledge receipt of the OHSAA Student Athlete Eligibility Guide which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the OHSAA Handbook is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the Handbook are also posted on the OHSAA web site at www.ohsaa.org.

understand that an OHSAA member school must adhere to all rules and regulations that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.

understand that participation in interscholastic athletics is a privilege not a right.

Student Code of Responsibility

As a student athlete, I understand and accept the following responsibilities:

will respect the rights and beliefs of others and will treat others with courtesy and consideration.

will be fully responsible for my own actions and the consequences of my actions.

will respect the property of others.

I will respect and obey the rules of my school and laws of my community, state and country.

I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state and country.

I understand that a student whose character or conduct violates the school's Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period of time as determined by the principal.

Informed Consent – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.

I understand that in the case of injury or illness requiring treatment by medical personnel and transportation to a health care facility, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital.

consent to medical treatment for the student following an injury or illness suffered during practice and/or a contest.

To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school I consent to the release to the OHSAA any and all portions of school record files, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s)or quardian(s), residence address of the student, academic work completed, grades received and attendance data.

consent to the OHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

understand that if I drop a class, take course work through Post Secondary Enrollment Option, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility.

I understand all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required in order for the student to return to participation.

have read and signed the Ohio Department of Health's Concussion Information Sheet and have retained a copy for myself.

By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.

*Must Be Signed Before Physical Examination

Student's Signature	Birth date	Grade in School	Date
Parent's or Guardian's Signature			Date