OHIO HIGH SCHOOL ATHLETIC ASSOCIATION
STUDENT PARTICIPATION AND PHYSICAL EXAM FORM

PLEASE TYPE OR PRINT:

STUDENT'S NAME_____ BIRTH DATE_____ SEX_____ GRADE_____
LAST FIRST M.I.

CITY_____ 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, ADDRESSS, 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 CONCIOUSNESS 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)