OSSAA PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM

PLEASE PRINT				DATE OF EXAM			
Name		_ Sex	ζ	Age Date of Birth			
Grade School				Sport(s)			
Address				Phone			
Personal physician				Phone			
In case of emergency, contact: Name							
Relationship			Phone ((W)			
Explain "Yes" answers below. Circle questions you don't know the a	nswers to.						
 Have you had a medical illness or injury since your last ch 	YES eck	<u>NO</u>			<u>Y</u>	ES	NO
up or sports physical?				Have you ever had numbness or tingling in your arms, handlegs, or feet?	ds,	П	
Do you have an ongoing or chronic illness?			8.	Have you ever become ill from exercising in the heat?			
2. Have you ever been hospitalized overnight?			9.	Do you cough, wheeze, or have trouble breathing during or	ŗ		
Have you ever had surgery?				after activity?			
 Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler 				Do you have asthma?			
Have you ever taken any supplements or vitamins to help				Do you have seasonal allergies that require medical treatme	ent?		
gain or lose weight or improve your performance?			10.	Do you use any special protective or corrective equipment devices that aren't usually used for your sport or position (1)			
4. Do you have any allergies (for example, to pollen, medicin food, or stinging insects)?	ne,			example, knee brace, special neck roll, foot orthotics, retain on your teeth, hearing aid)?			
Have you ever had a rash or hives develop during or after exercise?	П		11.	Have you had any problems with your eyes or vision?			
5. Have you ever passed out during or after exercise?				Do you wear glasses, contacts, or protective eyewear?			
Have you ever been dizzy during or after exercise?			12.	Have you ever had a sprain, strain, or swelling after injury?	?		
Have you ever had chest pain during or after exercise?				Have you broken or fractured any bones or dislocated any joints?		П	П
Do you get tired more quickly than your friends do during exercise?				Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?			
Have you ever had racing of your heart or skipped heartbe	ats?			If yes, check appropriate box and explain below.			
Have you had high blood pressure or high cholesterol?				☐ Head ☐ Elbow ☐ I ☐ Neck ☐ Forearm ☐ I	Hip Thigh		
Have you ever been told you have a heart murmur?					Knee		
Has any family member or relative died of heart problems of sudden death before age 50?	or			☐ Shoulder ☐ Finger ☐ A	Shin/calf Ankle Foot		
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?			13.	Do you want to weigh more or less than you do now?			
Has a physician ever denied or restricted your participation sports for any heart problems?	n in			Do you lose weight regularly to meet weight requirements your sport?	tor		
6. Do you have any current skin problems (for example, itchi rashes, acne, warts, fungus, or blisters)?	ng,		14. 15.	Do you feel stressed out? Record the dates of your most recent immunizations (shots)) for:		
7. Have you ever had a head injury or concussion?				Tetanus Measles Hepatitis Chickenpox			
Have you ever been knocked out, become unconscious, or your memory?	lost		F	Explain "Yes" answers on a separate sheet.			
Have you ever had a seizure?							
Do you have frequent or severe headaches?							
The above information is correct to the best of my knowledge understand the risk of injury in athletic participation. If recoaches, trainers or other personnel properly trained. I furth about the above-mentioned student may be disclosed to OSS an/or any possible violation of OSSAA rules. OSSAA will us that such information has not otherwise been publicly disclose	ny son/daug er acknowle SAA in conn ndertake rea	thter land the design of the d	nd con nd with ole mea	es ill or is injured, necessary medical care can be institute sent that, as a condition for participating in activities, identifany investigation or inquiry concerning the student's eligibi	ed by p fying in lity to p	hysic form partic	cians ation cipate
Signature of parent/guardian				Date			_
Signature of athlete							

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 E			
Vision: R 20/ L 20/_	Corrected	Y/N	Pupils: Equa	al	Unequ	al				
MEDICAL	Normal	Abnorr	nal 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				Pl	none					
Signature of Examiner										