

## Consent for Pre-Participation Physical

To obtain a pre- participation physical held at the  
Orthopaedic Institute of Ohio  
**this form MUST be signed.**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to be evaluated for an athletic  
(Student's Name)

pre-participation physical examination, including a screening survey, held at the Orthopaedic Institute of Ohio. I understand

treatment will not be given without further authorization and consent.

\_\_\_\_\_  
**Parent's or Legal Guardian's Signature**

\_\_\_\_\_  
**Date**

Please circle: Relationship to student: Mother/ Father/ Legal Guardian

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PREPARTICIPATION PHYSICAL EVALUATION 2019-2020

HISTORY FORM – Please be advised that this paper form is no longer the OHSAA standard.

(Note: This form is to be filled out by the student and parent prior to seeing the medical examiner.)

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Email) \_\_\_\_\_

Medicines and Allergies: Please list the prescription and over-the-counter medicines and supplements (herbal and nutritional-including energy drinks/ protein supplements) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

- Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

Table with 3 columns: Question, Yes, No. Contains sections: GENERAL QUESTIONS, HEART HEALTH QUESTIONS ABOUT YOU, HEART HEALTH QUESTIONS ABOUT YOUR FAMILY, BONE AND JOINT QUESTIONS.

Table with 3 columns: Question, Yes, No. Contains section: BONE AND JOINT QUESTIONS - CONTINUED.

Table with 3 columns: Question, Yes, No. Contains sections: MEDICAL QUESTIONS, FEMALES ONLY.

Explain "yes" answers here

Blank lines for explaining "yes" answers.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date: \_\_\_\_\_

The student has family insurance Yes No If yes, family insurance company name and policy number: \_\_\_\_\_



# Ohio High School Athletic Association



PREPARTICIPATION PHYSICAL EVALUATION 2019-2020

## THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

**PLEASE COMPLETE ONLY IF YOUR STUDENT HAS SPECIAL NEEDS OR A DISABILITY.**

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	<b>Yes</b>	<b>No</b>
6.	Do you regularly use a brace, assistive device or prosthetic?	
7.	Do you use a special brace or assistive device for sports?	
8.	Do you have any rashes, pressure sores, or any 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 have 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 with 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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate if you have ever had any of the following.

	<b>Yes</b>	<b>No</b>
	Atlantoaxial instability	
	X-ray evaluation for atlantoaxial instability	
	Dislocated joints (more than one)	
	Easy bleeding	
	Enlarged spleen	
	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	
	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 above questions are complete and correct.

Signature of Student \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date: \_\_\_\_\_



PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

PHYSICIAN REMINDERS

- 1. 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).

Table with columns for EXAMINATION, DATE OF EXAMINATION, and ABNORMAL FINDINGS. Rows include Height, Weight, BP, Pulse, Vision, and various medical and musculoskeletal categories.

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

CLEARANCE FORM

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

Name \_\_\_\_\_ Sex  M  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 \_\_\_\_\_

Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

\_\_\_\_\_

I have examined the above-named student and completed the pre-participation 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).

Name of physician or medical examiner (print/type) \_\_\_\_\_ Date of Exam \_\_\_\_\_

Address \_\_\_\_\_ 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 \_\_\_\_\_

Allergies \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Information \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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 2019-2020**

I hereby authorize the release and disclosure of the personal health information of \_\_\_\_\_ ("Student"), as described below, to \_\_\_\_\_ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: \_\_\_\_\_

School Address: \_\_\_\_\_

This authorization will expire when the student is no longer enrolled as a student at the school.

**NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.**

\_\_\_\_\_  
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 (documentation must be provided)

\_\_\_\_\_  
Signature of Student's personal representative, if applicable Date

**A copy of this signed form has been provided to the student or his/her personal representative**



# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING   0   +      +      +       
\*Total Score:     

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>