

PREPARTICIPATION PHYSICAL EVALUATION - Ohio High School Athletic Association - 2023-2024

PHYSICAL EXAMINATION FORM

Name:	_ Date of Birth:	Grade in School: ————
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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, e-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-enhancing 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, and use condoms?
- 2. Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

2. Co	nsider r	eviewing	ques	tions on cardio	rascular symptoms (Q4–Q13	of History For	11).		
EXAM	INATION					Carrier Service			
Height	:			Weight:					
BP:	/	(/	')	Pulse:	Vision: R 20/	L 20/	Correc	ted: 🗆 Y	□ N
MEDIO	CAL							NORMAL	ABNORMAL FINDINGS
	rfan stig			iosis, high-arched se [MVP], and aor	palate, pectus excavatum, aracl tic insufficiency)	hnodactyly, hyperl	laxity,		
	oils equal	e, and thre	oat						
Lymph	nodes								
Heart ^a • Mu	ırmurs (a	uscultatio	n stand	ling, auscultation s	supine, and ± Valsalva maneuver)			
Lungs						and the second s			<u> </u>
Abdon	nen								
	rpes simp ea corpor		HSV), le	esions suggestive o	f methicillin-resistant Staphyloco	ccus aureus (MRSA	A), or		
Neuro	logical								
MUSC	ULOSKE	ETAL						NORMAL	ABNORMAL FINDINGS
Neck									
Back									
Should	ler and a	rm							
Elbow	and fore	arm							
Wrist,	hand, an	d fingers							
Hip an	d thigh								
Knee									
Leg an	d ankle								
Foot ar	nd toes								
Function Do		quat test,	single	-leg squat test, and	d box drop or step drop test				
nation o	f those.				raphy, referral to a cardiologist				
	HEAILII C		cional	(print or type).				Date:	
Address:		are profes	sional						

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PREPARTICIPATION PHYSICAL EVALUATION | OHIO HIGH SCHOOL ATHLETIC ASSOCIATION - 2023-2024

MEDICAL ELIGIBILITY FORM _____ Date of Birth: _____ Grade in School: ___ Name: __ $\ \square$ Medically eligible for all sports without restriction ☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of ☐ Medically eligible for certain sports $\hfill\Box$ Not medically eligible pending further evaluation □ Not medically eligible for any sports Recommendations: _____ I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians). Date of Exam:_____ Name of health care professional (print or type): ______ Phone: _____ _____, MD, DO, DC, NP, or PA Signature of health care professional:____ SHARED EMERGENCY INFORMATION Allergies: ____ Medications: ___ Other information: Emergency contacts:

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PREPARTICIPATION PHYSICAL EVALUATION | Ohio High School Athletic Association - 2023-2024

HISTORY FORM

Note: Complete and sign this form (with your parents if you	nger than 1	8) before your app	ointment.	
Name:	D	ate of birth:	Grade in School:	
Date of examination:	Sport(s):_			
Sex assigned at birth (F, M, or intersex):	How do y	ou identify your g	ender? (F, M, or other):	
List past and current medical conditions:				_
Have you ever had surgery? If yes, list all past surgical proc	cedures:			
Medicines and supplements: List all current prescriptions, o	over-the-cou	nter medicines, an	d supplements (herbal and nutritional):	
Do you have any allergies? If yes, please list all your allergies	s (i.e., medic	ines, pollens, food,	stinging insects):	
Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been bothered			ems? (Circle response.) Over half the days Nearly every day	ı
·		22.2.2.40		!

	Patient Health Questionnaire Version 4 (PHQ-4)				
1	Over the last 2 weeks, how often have you been both	ered by any of t	the following prob	lems? (Circle response.,)
1		Not at all	Several days	Over half the days	Nearly every day
١	Feeling nervous, anxious, or on edge	0	1	2	3
1	Not being able to stop or control worrying	0	1	2	3
1	Little interest or pleasure in doing things	0	1	2	3
١	Feeling down, depressed, or hopeless	0	1	2	3
	(A sum of \geq 3 is considered positive on either sub	scale [question	ns 1 and 2, or ques	tions 3 and 4] for scree	ening purposes.)

(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
 Do you have any concerns that you would like to discuss with your provider? 		
Has a provider ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

ONE & JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a		
bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle	<u> </u>	
(males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or		
methicillin-resistant Staphylococcus aureus (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or		
memory problems?		
21. Have you ever had numbness, had tingling, had		
weakness in your arms or legs, or been unable to move your arms or legs after being hit or		
falling?		
22. Have you ever become ill while exercising in the		
heat?	<u> </u>	
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had, or do you have any problems with your eyes or vision?		

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I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete

and correct.

Signature of athlete: _____

Signature of parent or guardian: