**Return** **Pages** **1-5** **to** **the** **FUHS** **Athletic** **Dept**. **Pages** **6-12** **are** **for** **the** **athlete's** **reference** **and** **are** **signed** **on** **line.** Page 1 of 12

**PREPARTICIPATION** **PHYSICALEVALUATION** **|** **Ohio** **High** **School** **Athletic** **Association** **–** **2022-2023**

**HISTORY** **FORM**

**Note**: Complete and sign this form (with your parents if younger than 18) before your appointment. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade in School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of examination:

Sex assigned at birth (F, M, or intersex):

Sport(s):

How do you identify your gender? (F, M, or other):

List past and current medical conditions:

Have you ever had surgery? If yes, list all past surgical procedures:

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all your allergies (i.e., medicines, pollens, food, stinging insects):

Patient Health Questionnaire Version 4 (PHQ-4)

*Over* *the* *last* *2* *weeks,* *how* *often* *have* *you* *been* *bothered* *by* *any* *of* *the* *following* *problems?* *(Circle* *response.)*

Feeling nervous, anxious, or on edge

Not being able to stop or control worrying Little interest or pleasure in doing things

Feeling down, depressed, or hopeless

Not at all 0 0 0

0

Several days 1 1 1

1

Over half the days 2 2 2

2

Nearly every day 3 3 3

3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

|  |  |  |
| --- | --- | --- |
| **GENERAL** **QUESTIONS**  **(Explain** **“Yes”** **answers** **at** **the** **end** **of** **this** **form.**  **Circle** **questions** **if** **you** **don’t** **know** **the** **answer.)** | **Yes** | **No** |
| 1. Do you have any concerns that you would like to discuss with your provider? |  |  |
| 2. Has a provider ever denied or restricted your participation in sports for any reason? |  |  |
| 3. 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? |  |  |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. |  |  |

|  |  |  |
| --- | --- | --- |
| **HEART** **HEALTH** **QUESTIONS** **ABOUT** **YOU**  **(*CONTINUED*** **)** | **Yes** | **No** |
| 9. 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 poly-morphic ventricular tachycardia (CPVT)? |  |  |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? |  |  |

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|  |  |  |
| --- | --- | --- |
| **BONE** **&** **JOINT** **QUESTIONS** | **Yes** | **No** |
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon thatcaused 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 (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? |  |  |
| 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? |  |  |

|  |  |  |
| --- | --- | --- |
| **MEDICAL** **QUESTIONS** **(*CONTINUED*** **)** | **Yes** | **No** |
| 25. Do you worry about your weight? |  |  |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? |  |  |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? |  |  |
| 28. Have you ever had an eating disorder? |  |  |
| **FEMALES** **ONLY** | **Yes** | **No** |
| 29. Have you ever had a menstrual period? |  |  |
| 30. How old were you when you had your first menstrual period? |  | |
| 31. When was your most recent menstrual period? |  | |
| 32. How many periods have you had in the past 12 months? |  | |

Explain “Yes” answers here:

…continued next page…

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Additional questions, as authorized by the Ohio High School Athletic Association, were not a part of the

revised 5th edition PPE as authored by the American Academy of Pediatrics and are optional.

1. On average, how many days per week do you engage in moderate to strenuous exercise (makes you breathe heavily or sweat)?

2. On average, how many minutes per week do you engage in exercise at this level?

3. Have you had COVID-19 or tested positive for COVID-19?

4. If answered yes, when did you have/test positive for COVID-19?

5. If answered yes, have you had any ongoing medical issues secondary to COVID-19?

6. If answered yes, were you cleared by a health care provider following the diagnosis to return to sport

activity?

7. Has a physician ever denied or restricted your participation in sports for reasons related to COVID-19?

8. If answered yes, please state reasoning:

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:

Date:

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**PREPARTICIPATION** **PHYSICALEVALUATION** **|** **Ohio** **High** **School** **Athletic** **Association** **–** **2022** **–** **2023**

**ATHLETES** **WITH** **DISABILITIES** **FORM:** **SUPPLEMENT** **TO** **THE** **ATHLETE** **HISTORY**

Name: Date of birth:

1. Type of disability: 2. Date of disability:

3. Classification (if available):

4. Cause of disability (birth, disease, injury, or other): 5. List the sports you are playing:

**Yes** **No** 6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?

7. Do you use any special brace or assistive device for sports?

8. Do you have any rashes, pressure sores, or 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 use 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 as having 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 whether you have ever had any of the following conditions:

**Yes** **No** Atlantoaxial instability

Radiographic (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 questions on this form are complete and correct.

Signature of athlete:

Signature of parent or guardian:

Date:

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**PREPARTICIPATION** **PHYSICALEVALUATION** **–** **Ohio** **High** **School** **Athletic** **Association** **–** **2022-2023**

**PHYSICAL** **EXAMINATION** **FORM**

Name: Date of Birth: Grade in School:

***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).

a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combi-nation of those.

Name of health care professional (print or type): Date:

Address: Phone:

Signature of health care professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, MD, DO, DC, NP,or PA

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**PREPARTICIPATION** **PHYSICAL** **EVALUATION** **|** **OHIO** **HIGH** **SCHOOL** **ATHLETIC** **ASSOCIATION** **–** **2022-2023**

**MEDICAL** **ELIGIBILITY** **FORM**

Name: Date of Birth: Grade in School:

□ 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

□ 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).

Name of health care professional (print or type): **Date** **of** **exam:**

Address: Phone:

**Signature** **of** **health** **care** **professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** **MD,** **DO,** **DC,** **NP,** **or** **PA**

**SHARED** **EMERGENCY** **INFORMATION**

Allergies:

Medications:

Other information:

Emergency contacts:

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**PREPARTICIPATION** **PHYSICAL** **EVALUATION** **|** **2022-2023** **Parent/Athlete** **keep** **this**

**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** **|** **2022-2023**

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: FUHS-Matt McPhail; RMS-Tricia Haughn

School Address: 6675/6409 Cincinnati-Zanesville Rd. NE, Lancaster, OH 43130

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

**Parent/Athlete** **keep** **this** **page** **for** **your** **reference.**

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

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**Parent/Athlete** **keep** **this** **page** **for** **your** **reference.** **PREPARTICIPATION** **PHYSICAL** **EVALUATION** **|** **2022-2023**

**2022-2023** **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* *guardian*

I have read, understand and acknowledge receipt of the **OHSAA** **Student** **Eligibility** **Guide** **and** **Checklist** [(https://ohsaaweb.blob.core.windows.net/files/Eligibility/OtherEligibiltyDocs/EligibilityGuideHS.pdf)](https://ohsaaweb.blob.core.windows.net/files/Eligibility/OtherEligibiltyDocs/EligibilityGuideHS.pdf) 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 website a[t ohsaa.org.](http://www.ohsaa.org/)

I 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.

I 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:

• I will **respect** **the** **rights** **and** **beliefs** of others and will treat others with courtesy and consideration. • I will be **fully** **responsible** for my own actions and the consequences of my actions.

• I 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 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.

• I **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 guardian(s), enrollment documents, financial and scholarship records, residence address of the student, academic work completed, grades received and attendance data.

• I **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.

I **understand** **that** **if** **I** **drop** **a** **class**, take course work through College Credit Plus, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility. **I** **accept** **full** **responsibility** for compliance with Bylaw 4-4, Scholarship, and the passing five credit standard expressed therein.

• 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 another health care provider working under the supervision of a physician will be required in order for the student to return to participation.

• I **have** **read** **and** **signed** the Ohio Department of Health’s **Concussion Information Sheet** and have retained a copy for myself.

• I **have** **read** **and** **signed** the Ohio Department of Health’s **Sudden Cardiac Arrest 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** **Parent/Athlete** **keep** **this** **page** **for** **your** **reference.**

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

Student’s Signature Birth Date Grade in School Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Parent’s or Guardian’s Signature Date Page 8 of 12

**Parent/Athlete** **keep** **this** **page** **for** **your** **reference.**

**Ohio** **Department** **of** **Health** **Concussion** **Information** **Sheet** **For** **Interscholastic** **Athletics**

Dear Parent/Guardian and Athletes,

This information sheet is provided to assist you and your child in recognizing the signs and symptoms of a concussion. Every

athlete is different and responds to a brain injury differently, so seek medical attention if you suspect your child has a concus-sion. Once a concussion occurs, it is very important your athlete return to normal activities slowly, so he/she does not do more

damage to his/her brain.

**What** **is** **a** **Concussion?**

A concussion is an injury to the brain that may be caused by a

blow, bump, or jolt to the head. Concussions may also happen after a fall or hit that jars the brain. A blow elsewhere on the body can cause a concussion even if an athlete does not hit

his/her head directly. Concussions can range from mild to

severe, and athletes can get a concussion even if they are

wearing a helmet.

**Signs** **and** **Symptoms** **of** **a** **Concussion**

Athletes do not have to be “knocked out” to have a concussion. In fact, lessthan 1 out of 10 concussions result in loss of consciousness. Concussion symptoms can develop right away

or up to 48 hours after the injury. Ignoring any signs or

symptoms of a concussion puts your child’s health at risk!

**Signs** **Observed** **by** **Parents** **of** **Guardians** i Appears dazed or stunned.

i Is confused about assignment or position. i Forgets plays.

i Is unsure of game, score or opponent. i Moves clumsily.

i Answers questions slowly.

i Loses consciousness (even briefly).

i Showsbehavior or personality changes(irritability,

sadness, nervousness, feeling more emotional). i Can’t recall events before orafter hit orfall.

**Symptoms** **Reported** **by** **Athlete**

i Any headache or “pressure”in head. (How badly it hurts

does not matter.)

i Nausea or vomiting.

i Balance problems or dizziness. i Double or blurry vision.

i Sensitivity tolight and/or noise

i Feeling sluggish, hazy, foggy orgroggy. i Concentrationor memory problems.

i Confusion.

i Does not “feel right.” i Trouble falling asleep.

i Sleepingmore or lessthan usual.

**Be** **Honest**

Encourage your athlete to be honest with you, his/her coach

and your health care provider about his/her symptoms. Many young athletes get caught up in the moment and/or feel pressured to return to sports before they are ready. It is better

to miss one game than the entire season… or risk permanent

damage!

**Seek** **Medical** **Attention** **Right** **Away**

Seeking medical attention is an important first step if you

suspect or are told your child has a concussion. A qualified health care professional will be able to determine how serious the concussion is and when it is

safe for your child to return to sports and other daily

activities.

i No athlete should return to activity on the same day

he/she gets a concussion.

i Athletes should NEVER return to practices/games if

they still have ANY symptoms.

i Parents and coaches should never pressure any

athlete to return to play.

**The** **Dangers** **of** **Returning** **Too** **Soon**

Returning to play too early may cause Second Impact

Syndrome (SIS) or Post-Concussion Syndrome (PCS). SIS occurs when a second blow to the head happens before an athlete has completely recovered from a

concussion. This second impact causes the brain to

swell, possibly resulting in brain damage, paralysis, and even death. PCS can occur after a second impact. PCS can result in permanent, long-term concussion

symptoms. The risk of SIS and PCS is the reason why

no athlete should be allowed to participate in any physical activity before they are cleared by a qualified

healthcare professional.

**Recovery**

A concussion can affect school, work, and sports. Along

with coaches and teachers, the school nurse, athletic trainer, employer, and other school administrators should be aware of the athlete’s injury and their roles in helping

the child recover.

During the recovery time after a concussion, physical and

mental rest are required. A concussion upsets the way

the brain normally works and causes it to work longer and harder to complete even simple tasks. Activities that require concentration and focus may make symptoms

worse and cause the brain to heal slower. Studies show

that children’s brains take several weeks to heal following

a concussion.

**hƩp://www.healthy.ohio.gov/vipp/child/returntoplay/concussion** Page 9 of 12 **Rev.** **09.16**

**Returning** **to** **Daily** **Activities** **Returning** **to** **Play** **Parent/Athlete** **keep** **this** **page** **for** **your** **reference**.

1. Be sure your child gets plenty of rest and enough

sleep at night – no late nights. Keep the same

bedtime weekdays and weekends.

2. Encourage daytime naps or rest breaks when your

child feels tired or worn-out.

3. Limit your child’s activities that require a lot of thinking

or concentration (including social activities,

homework, video games, texting, computer, driving,

activities can slow the brain’s recovery.

4. Limit your child’s physical activity, especially those activities where another injury or blow to the head

may occur.

**5.** Have your qualified health care professional check your child’s symptoms at different times to help guide

recovery.

1. Returning to play isspecific for each person, depending on

the sport.Starting 4/26/13, Ohio law requires written permission from a health care provider before an athlete can

return to play. Follow instructions and guidance providedby

a health care professional. It is important that you, your child

and your child’s coach follow these instructions carefully.

2. Your child should NEVER return to play if he/she still

has ANY symptoms. (Be sure that your child does

not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of

thinking or concentration).

3. Ohio law prohibits your child from returning to a game or practice on the same day he/she was

removed.

4. Be sure that the athletic trainer, coach and physical education teacher are aware of your child’s injury and

symptoms.

**Returning** **to** **Learn** **(School)**

1. Your athlete may need to initially return to school on a

limited basis, for example for only half-days, at first. This should be done under the supervision of a

qualified health care professional.

2. Inform teacher(s), school counselor or administrator(s) about the injury and symptoms. School personnel

should be instructed to watch for:

5. Your athlete should complete a step-by-step exercise -based progression, under the direction of a qualified

healthcare professional.

6. A sample activity progression is listed below. Generally, each step should take no less than 24

hours so that your child’s full recovery would take

about one week once they have no symptoms at rest

and with moderate exercise.\*

a. Increased problems paying attention.

b. Increased problems remembering or learning new

information.

c. Longer time needed to complete tasks or assignments.

d. Greater irritability and decreased ability to cope with

stress.

e. Symptoms worsen (headache, tiredness) when doing

schoolwork.

3. Be sure your child takes multiple breaks during study

time and watch for worsening of symptoms.

4. If your child is still having concussion symptoms, he/

related activities. As the symptoms decrease during recovery, the extra

help or supports can be removed gradually.

5. For more information, please refer to Return to Learn on the ODH website.

**Resources**

**ODH** **Violence** **and** **Injury** **Prevention** **Program** **http://www.healthy.ohio.gov/vipp/child/returntoplay/**

**Centers** **for** **Disease** **Control** **and** **Prevention** **http://www.cdc.gov/headsup/basics/index.html**

**NationalFederationofStateHighSchoolAssociations** **www.nfhs.org**

**Sample** **Activity** **Progression\***

**Step** **1**: Low levels of non-contact physical activity, provided NO SYMPTOMS return during or after activity.

(Examples: walking, light jogging, and easy stationary

moderate stationary biking,i light rcalisthenics,tand rsportǦ

**Step**t**3**: Heavy, nonǦcontact physical activity, provided

NO SYMPTOMS return during or after activity.

(Examples: extensive sprint running, high intensity

stationary biking,i resistance exercise with machinesf and

minutes).

**Step** **4**: Full contact in controlled practice or scrimmage.

**Step** **5**: Full contact in game play.

**\*If** **any** **symptoms** **occur,** **the** **athlete** **should** **drop** **back** **to** **the** **previous** **step** **and** **try** **to** **progress** **again** **after** **a** **24**

**hour** **rest** **period**.

**Brain** **Injury** **Association** **of** **America** **www.biausa.org/**

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**Ohio** **Department** **of** **Health** **Concussion** **Information** **Sheet** **For** **Interscholastic** **Athletics** **Parent/Athlete** **keep** **this** **page**

I have read the Ohio Department of Health’s Concussion Information Sheet and understand that I have a responsibility to report my/my child’s symptoms to coaches, administrators and healthcare provider.

I also understand that I/my child must have no symptoms before return to play can occur.

Athlete Date

Athlete Please Print Name

Parent/Guardian Date

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**Parent/Athlete** **keep** **this** **page** **for** **your** **reference.**

**Sudden** **Cardiac** **Arrest** **and** **Lindsay’s** **Law** **Parent/Athlete** **Signature** **Form**

What is Lindsay’s Law? Lindsay’s Law is about Sudden Cardiac Arrest (SCA) in youth athletes. It covers all athletes 19 years or younger who practice for or compete in athletic activities. Activities may be organized by a school or youth sports organization.

Which youth athletic activities are included in Lindsay’s law? • Athletics at all schools in Ohio (public and non-public)

• Any athletic contest or competition sponsored by or associated with a school

• All interscholastic athletics, including all practices, interschool practices and scrimmages • All youth sports organizations

• All cheerleading and club sports, including noncompetitive cheerleading

What is SCA? SCA is when the heart stops beating suddenly and unexpectedly. This cuts off blood ﬂow to the brain and other vital organs. People with SCA will die if not treated immediately. SCA can be caused by 1) a structural issue with the heart, OR 2) an heart electrical problem which controls the heartbeat, OR 3) a situation such as a person who is hit in the chest or a gets a heart infection.

What is a warning sign for SCA? If a family member died suddenly before age 50, or a family member has cardiomyopathy, long QT syndrome, Marfan syndrome or other rhythm problems of the heart.

What symptoms are a warning sign of SCA? A young athlete may have these things with exercise: • Chest pain/discomfort

• Unexplained fainting/near fainting or dizziness

• Unexplained tiredness, shortness of breath or difﬁculty breathing • Unusually fast or racing heart beats

What happens if an athlete experiences syncope or fainting before, during or after a practice, scrimmage, or competitive play? The coach MUST remove the youth athlete from activity immediately. The youth athlete MUST be seen and cleared by a health care provider before returning to activity. This written clearance must be shared with a school or sports ofﬁcial.

What happens if an athlete experiences any other warning signs of SCA? The youth athlete should be seen by a health care professional.

Who can evaluate and clear youth athletes? A physician (MD or DO), a certiﬁed nurse practitioner, a clinical nurse specialist, certiﬁed nurse midwife. For school athletes, a physician’s assistant or licensed athletic trainer may also clear a student. That person may refer the youth to another health care provider for further evaluation.

What is needed for the youth athlete to return to the activity? There must be clearance from the health care provider in writing. This must be given to the coach and school or sports ofﬁcial before return to activity.

All youth athletes and their parents/guardians must review information about Sudden Cardiac Arrest, then sign and return this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Name (Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

**Department** **of** **Health**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Name (Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

**Department** Page 12 o**of** **Education**