## OSSAA PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM

PLEASE PRINT					DATE OF EXAM			
Name		Sex		Age Da	te of Birth			
GradeSchool				Spo	ort(s)			
Address					Phone			
Personal physician					Phone			
In case of emergency, contact: Name								
Relationship		Ph	one (H)		(W)			
Explain "Yes" answers below. Circle questions you don't know	the answers to.							
Have you had a medical illness or injury since your la up or sports physical?		<u>NO</u> □	24.	Have you ever had nur legs, or feet?	mbness or tingling in your ar	YES ms, hands,	NO	
Do you have an ongoing or chronic illness?			25.	Have you ever become	e ill from exercising in the he	at?		
Have you ever been hospitalized overnight?			26.	Do you cough, wheeze	e, or have trouble breathing d	uring or		
Have you ever had surgery?				after activity?				
Are you currently taking any prescription or nonprescription			27.	Do you have asthma?				
(over-the-counter) medications or pills or using an inl			28.	Do you have seasonal	allergies that require medica	l treatment?		
Have you ever taken any supplements or vitamins to gain or lose weight or improve your performance?	help you		29.	disease?	ne in your family have sickle			
Do you have any allergies (for example, to pollen, me food, or stinging insects)?			30.	devices that aren't usue example, knee brace, s	l protective or corrective equally used for your sport or popecial neck roll, foot orthotic	osition (for		
Have you ever had a rash or hives develop during or a exercise?	after $\Box$		21	on your teeth, hearing		2		
Have you ever passed out during or after exercise?			31.		olems with your eyes or visio			
Have you ever been dizzy during or after exercise?			32.		contacts, or protective eyewe			
Have you ever had chest pain during or after exercise	?		33.	,	orain, strain, or swelling afte	, ,		
Do you get tired more quickly than your friends do de exercise?			34.	joints?	actured any bones or dislocat			
Have you ever had racing of your heart or skipped he	_		35.	Have you had any other muscles, tendons, bone	er problems with pain or swe es, or joints?	lling in		
Have you had high blood pressure or high cholesterol			36.		ite box and explain below.		_	
Have you ever been told you have a heart murmur?				☐ Head	☐ Elbow	□Hip		
Has any family member or relative died of heart prob of sudden death before age 50?	<del></del>			☐ Neck ☐ Back ☐ Chest	☐ Forearm ☐ Wrist ☐ Hand	☐ Thigh ☐ Knee ☐Shin/ca	lf	
Have you had a severe viral infection (for example,				Shoulder	☐ Finger	Ankle		
myocarditis or mononucleosis) within the last month			27	Upper arm	more or less than you do no	☐ Foot		
Has a physician ever denied or restricted your participal sports for any heart problems?	oation in		37. 38.	Do you lose weight reg	gularly to meet weight requir			
Do you have any current skin problems (for example, rashes, acne, warts, fungus, or blisters)?	itching,		39.	your sport?  Do you feel stressed or	ut?			
Have you ever had a head injury or concussion?			40.	Record the dates of yo	ur most recent immunization	s (shots) for:		
Have you ever been knocked out, become unconsciou your memory?	is, or lost			Hepatitis	Measles Chickenpox			
Have you ever had a seizure?			1	Explain "Yes" answers	on a separate sheet.			
Do you have frequent or severe headaches?								
The above information is correct to the best of my known the risk of injury in athletic participation. If my son/da other personnel properly trained. I further acknowledge student may be disclosed to OSSAA in connection with rules. OSSAA will undertake reasonable measure to a publicly disclosed in some manner.	aughter becomes ge and consent the any investigation	ill or is nat, as a n or inqu	injured, r condition uiry conce	necessary medical care c for participating in action for participating in action actions are carried to the student's eligi-	an be instituted by physiciar ivities, identifying informational bility to participate an/or any	ns, coaches, at on about the a y possible viol	thletic above- lation	tra -me of (
Signature of parent/quardian		Signat	ture of Atl	alata		Data		

## PREPARTICIPATION PHYSICAL EVALUATION

PLEASE PRINT		DATE OF EXAM							
Name				Date of Birth					
Height Weight I	Body fat (optional)	% Pulse	BP	/ Color Blind	d Yes No	(circle one)			
Vision: R 20/	L 20/	Corrected	1 Y/N	Pupils: Equal	Unequal				
MEDICAL	Normal	Abnorma	ıl Findings						
Appearance	T (OTTIME								
Eyes/Ears/Throat									
Lymph Nodes									
Heart									
Pulses									
Lungs									
Abdomen									
Genitalia (male only)									
Skin									
MUSCULOSKELETAL									
Neck									
Back									
Shoulder/Arm									
Elbow/Forearm									
Wrist/Hand									
Hip/Thigh									
Knee									
Leg/Ankle									
Foot									
CLEARANCE									
( ) Cleared									
( ) Cleared after completing evalu	nation/rehabilitation for	r:							
( ) Not cleared for:	Daggar								
( ) Not cleated for	Keason	•							
Recommendations:									
Name & Title of Examiner (Pri	nt/Tyne)			Date					
rame & The of Examine (FII	ши турсј			Date					
Address				Phone					
Signature of Examiner									