

# OSSAA PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM

PLEASE PRINT

DATE OF EXAM \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Address \_\_\_\_\_ Phone \_\_\_\_\_

Personal physician \_\_\_\_\_ Phone \_\_\_\_\_

In case of emergency, contact: Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_

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

	YES	NO		YES	NO
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve performance?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below?		
Have you ever had racing of your heart or skipped heart beats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip		
Have you ever had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee		
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/ calf		
Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle		
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper arm <input type="checkbox"/> Foot		
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	Record the dates of your most recent immunizations (shots) for:		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____ Measles _____		
			Hepatitis _____ Chickenpox _____		
			Explain "Yes" answers on a separate sheet.		

The above information is correct to the best of my knowledge. I hereby give my informed consent for the above-mentioned student to participate in activities. I understand the risk of injury in athletic participation. If my son/daughter becomes ill or is injured, necessary medical care can be instituted by physicians, coaches, trainers, or other personnel properly trained. I further acknowledge and consent that, as a condition for participating in activities, identifying information about the above-mentioned student may be disclosed to OSSAA in connection with any investigation or inquiry concerning the student's eligibility to participate and/or any possible violation of OSSAA rules. OSSAA will undertake reasonable measure to maintain the confidentiality of such identifying information, provided that such information has not otherwise been publicly disclosed in some manner.

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 \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ )

Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected Y/N \_\_\_\_\_ Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_ Initial BP \_\_\_\_\_ Post Exercise \_\_\_\_\_ 5 Min. Post Ex. \_\_\_\_\_

MEDICAL                      Normal      Abnormal Findings

Appearance		
Eyes/Ears/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (male only)		
Skin		

MUSCULOKETAL

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 \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Examiner \_\_\_\_\_

**AUTHORIZATION FOR CARE OF A MINOR**

The undersigned parent or guardian has legal custody of the child named below. As such, he/she grants to the listed custodian-into whose care the child has been entrusted permission to authorize the following: x-ray exams, anesthetic, medicalurgical/dental diagnosis or treatment and hospital care for the child. All procedures must be recommended be a physician, surgeon or dentist licensed by the State of Oklahoma.

This consent, even if advance of a specific event, encourages the custodian to seek needed treatment for the child in the absence of a parent or guardian. It is effective until withdrawn in writing.

Dated: \_\_\_\_\_

Name and birthdate of child: \_\_\_\_\_

Name of custodian: \_\_\_\_\_

Signature of parent or legal guardian: \_\_\_\_\_  
\_\_\_\_\_

Signature of witness: \_\_\_\_\_

Special medical information regarding child (allergies, current medications, medical conditions): \_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Minor children must have parent or legal guardian consent for medical treatment. Except in a life threatening situation, treatment could not be administered without it. Persons entrusted with the care of your child cannot give medical consent for treatment until legally authorized by a parent or guardian. This consent form to legal authorization for medical and/or dental treatment can insure that your child will receive treatment without delay.

This form is provided by Valley View Regional Hospital as a service to the parent of our community.

The Roff School District is concerned about the safety of every student. In the past we observe that our athletes are involved in accidents that require professional medical treatment. We feel each athlete should have insurance.

The Roff Schools are in contact with an insurance company that sells a student policy that covers these athletes at school or on school sponsored activities. We believe the type and amount of coverage is inexpensive.

The Roff School will expect that every athlete does have some insurance. This insurance could be with his/her family or the student coverage through Midwest National Insurance Company that the school students have used in the past.

\_\_\_\_\_ Does have the student insurance.

\_\_\_\_\_  
Parent or Guardian Date

\_\_\_\_\_ Does have family insurance at home.

\_\_\_\_\_  
Parent or Guardian Date

\_\_\_\_\_ Does not have any insurance and the Roff School will not be held responsible for my child's medical payments.

\_\_\_\_\_  
Parent or Guardian Date