Updated February 2015

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) _____ (W) _____

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

		YES	NO
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Do you have an ongoing or chronic illness?	☐	☐
3.	Have you ever been hospitalized overnight?	☐	☐
4.	Have you ever had surgery?	☐	☐
5.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
6.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
7.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
8.	Have you ever had a rash or hives develop during or after exercise?	☐	☐
9.	Have you ever passed out during or after exercise?	☐	☐
10.	Have you ever been dizzy during or after exercise?	☐	☐
11.	Have you ever had chest pain during or after exercise?	☐	☐
12.	Do you get tired more quickly than your friends do during exercise?	☐	☐
13.	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
14.	Have you had high blood pressure or high cholesterol?	☐	☐
15.	Have you ever been told you have a heart murmur?	☐	☐
16.	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
17.	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
18.	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
19.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
20.	Have you ever had a head injury or concussion?	☐	☐
21.	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
22.	Have you ever had a seizure?	☐	☐
23.	Do you have frequent or severe headaches?	☐	☐

		YES	NO
24.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
25.	Have you ever become ill from exercising in the heat?	☐	☐
26.	Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
27.	Do you have asthma?	☐	☐
28.	Do you have seasonal allergies that require medical treatment?	☐	☐
29.	Do you or does someone in your family have sickle cell trait or disease?	☐	☐
30.	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)?	☐	☐
31.	Have you had any problems with your eyes or vision?	☐	☐
32.	Do you wear glasses, contacts, or protective eyewear?	☐	☐
33.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
34.	Have you broken or fractured any bones or dislocated any joints?	☐	☐
35.	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
36.	If yes, check appropriate box and explain below.		
37.	Do you want to weigh more or less than you do now?	☐	☐
38.	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
39.	Do you feel stressed out?	☐	☐

☐ Head ☐ Neck ☐ Back ☐ Chest ☐ Shoulder ☐ Upper arm
☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Finger
☐ Hip ☐ Thigh ☐ Knee ☐ Shin/calf ☐ Ankle ☐ Foot

40. Record the dates of your most recent immunizations (shots) for:
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, athletic 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 an/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 _____ Signature of Athlete _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION

PLEASE PRINT

DATE OF EXAM _____

Name _____ Date of Birth _____

Height _____ Weight _____ Body fat (optional) ____% Pulse _____ BP _____/_____ Color Blind Yes No (circle one)

Vision: R 20/_____ L 20/_____ Corrected Y / N Pupils: Equal _____ Unequal _____

MEDICAL	Normal	Abnormal Findings
Appearance		
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 evaluation/rehabilitation for: _____

( ) Not cleared for: _____ Reason: _____

Recommendations: _____

Name & Title of Examiner (Print/Type) _____ Date _____

Address _____ Phone _____

Signature of Examiner _____

A List of Requirements and Recommendations

For the Implementation of Oklahoma Statute 24-155 of Title 70 (Senate Bill 1700)

Concussion and Head Injury Awareness and Management

REQUIREMENTS

1. An acknowledgement statement from student-athlete and parent/guardian must be on file annually with the school district prior to the beginning of the athlete's practice/competition.
2. Athletes who are suspected of sustaining a concussion or head injury during practice or game must be removed from participation at that time.
3. Determine for your district the definition of *"a licensed health care provider trained in the evaluation and management of concussions"*.
4. An athlete who has been removed from participation may not participate until the athlete is evaluated by a licensed health care provider trained in the evaluation and management of concussion and receives *"written clearance"* to return to participation from that health care provider.

RECOMMENDATIONS

5. All district coaches view the 20-minute free video "Concussion in Sports: What You Need to Know" at the National Federation website at www.nfhslearn.com and that documentation of viewing be kept on file in the district.
6. Set forth policy and procedures for reporting and tracking student-athletes that have been determined to suffer a concussion or head injury.
7. Set forth policy and procedures for a step by step process for student-athletes that have been determined to suffer a concussion or head injury in order to facilitate the student-athletes safe return to practice and/or participation in competitive events.
8. Provide relevant information to all staff on where information on concussion and head injuries can be found on the OSSAA website at www.ossaa.com, the National Federation of State High School Associations website at www.nfhs.org, the Oklahoma Athletic Trainers Association website at www.oata.net and the Center for Disease Control website at www.cdc.gov/TraumaticBrain Injury.

Idabel Public Schools

200 NE Ave C, Idabel OK. 74745
Phone (580) 286-_____

School Site:_____

CONCUSSION & HEAD INJURY AWARENESS AND MANAGEMENT

ACKNOWLEDGEMENT FORM

In compliance with Oklahoma Statute (70 O.S. §24-155), this acknowledgement form is to confirm that you have read and understand the CONCUSSION AND HEAD INJURY FACT SHEET provided to you by a site within the Idabel Public School district related to potential concussions and head injuries occurring during participation in athletics.

I, _____, as a student-athlete who participates in Idabel Warrior
PLEASE PRINT STUDENT'S NAME

Athletics and I, _____, as the parent/legal guardian, have read the
PLEASE PRINT PARENT'S/LEGAL GUARDIAN'S NAME

information material provided to us by Idabel Public Schools related to concussions and head injuries occurring during participation in athletic programs and understand the content and warnings.

_____

SIGNATURE OF STUDENT-ATHLETE **DATE**

_____

SIGNATURE OF PARENT/LEGAL GUARDIAN **DATE**

This form shall be completed annually prior to the athlete's first practice and/or competition and will be kept on file for one year beyond the date of signature in the office of the Athletic Director.

Oklahoma State Department of Health

EDUCATION

Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs

_____

(NAME OF SCHOOL)

I have reviewed the Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms (SCA) and Warning Signs informational material jointly developed by Oklahoma State Department of Health and the Oklahoma State Department of Education and understand the symptoms and warning signs of SCA related to participation in athletic programs.

_____	_____	_____
Signature of Student-Athlete	Print Student-Athlete's Name	Date

_____	_____	_____
Signature of Parent/Guardian	Print Parent/Guardian's Name	Date

This form is required to be completed annually prior to the athlete's first practice and/or competition and be kept on file for one year beyond the date of signature in the principal's office or the office designated by the principal.

IDABEL
PUBLIC SCHOOLS

Medical Release Form

For Participation in IPS-Sponsored Activities

Student's Name _____ Grade _____

_____ has my permission to participate in any Idabel Public Schools-sponsored activity. To the best of my knowledge, the above named student is physically fit to participate in any school-sponsored activity. I understand that the Idabel Public Schools and the Idabel Board of Education are not financially responsible for any accident, or injuries, losses or damages which may result there from, if such accident involves the above-named student and occurs while such student is participating in athletics, any other extra-curricular activity of the Idabel Public Schools or traveling to or from any athletic event or other activity.

I have listed any health problems at the bottom of this form, such as allergies, medication, etc., of which any sponsor/coach/teacher/nurse needs to be aware.

In the event a custodial parent or legal guardian cannot be contacted, I hereby accept the emergency services of any physician available and further authorize any sponsor/coach/teacher/nurse to act in my behalf and sign such papers as may be required to obtain the medical attention necessary for the welfare and safety of my son/daughter/ward. I also authorize any physician to release confidential information concerning the above-named student to such sponsor/coach/teacher/nurse if necessary to effect such emergency services.

Student's Full Name _____ Date _____

Students Date of Birth _____ Parent or Guardian _____

Home /Cell Phone _____ Insurance Company _____

Policy Number _____ Signature of Parent or Guardian _____

List any medication(s) the student is now taking _____

_____

List any known allergies _____

List any other health-related problems _____

Health Form

AUTHORIZATION FOR EMERGENCY CARE TO A MINOR

I/We understand, parent(s) or legal guardian of the minor below:

Minor's Name: _____ Date of Birth: _____

Do hereby authorize any X-Ray examination, anesthetic, dental, medical or surgical diagnosis or treat by any licensed physician or dentist and hospital service that may be rendered to said minor under the general, specific or special consent **ANY IDABEL SCHOOL DISTRICT COACH WITH SCHOOL ID**.

Names of adult persons who are temporary custodians. Date: _____

The temporary custodian of the minor; whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at a hospital. I/we authorize the physician or dentist to call in necessary consultants in his/their discretion.

It is understood that this consent is given in advance or any specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor, and said physician or dentist to exercise his/their best judgement as to the requirements of such diagnosis or medical or dental treatment.

This consent shall remain effective until 12:00 p.m. on the 30th day of **May** _____.

List any allergies minor may have: _____

Insurance company: _____ Policy number: _____

MUST BE SIGNED IN THE PRESENCE OF A NOTARY

Father/Mother: _____ Legal Guardian: _____

I/We (circle one) DO/DO NOT authorize treatment of my child: _____

Notary Public _____

Subscribed and sworn to before me _____ (SEAL)

My commission expires _____