

OKLAHOMA SECONDARY SCHOOL ACTIVITIES ASSOCIATION
 PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM
 UPDATED APRIL 2021



PLEASE PRINT

NAME: _____ GENDER _____ AGE _____ DATE OF BIRTH _____

GRADE _____ SCHOOL _____ ACTIVITIES _____

ADDRESS _____

PHYSICIAN'S NAME _____ PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE OF EMERGENCY CONTACT _____
 PLEASE EXPLAIN ALL YES ANSWERS ON A SEPARATE SHEET

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

	YES	NO
23. Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
24. Have you ever become ill from exercising in the heat?		
25. Have you ever tested positive for COVID?		
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, circle appropriate affected area 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 activity?		
39. Do you feel stressed?		
40. Record the dates of your most recent immunizations for: Tetanus _____ Measles _____ Hepatitis _____ Chickenpox _____		

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 with 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 GUARDIAN _____ SIGNATURE OF STUDENT _____

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: _____

Printed name of Examiner _____

Address: _____ Phone: _____

Date: _____ Signature: _____