Sports Physicals: If the child's parent can't be there, the parent MUST complete ALL of the paperwork, including signature. On the questionnaire; if YES is marked, please explain why the "yes" was marked on a separate piece of paper with details for our Nurse Practitioner.

OKLAHOMA SECONDARY SCHOOL ACTIVITIES ASSOCIATION
PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM

PLEASE PRINT

UPDATED APRIL 2021

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:_____

Consent for Service / Texting / Email

Name _____ **Date of Birth** _____

I, the undersigned, give my consent for the services that I am requesting from the Oklahoma State Department of Health (OSDH) and its entities/contractors. I understand that the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions.

I also understand that:

- The information regarding myself and the services I receive will be entered into OSDH information systems and may be used for program evaluation, management, and billing purposes.
- I will not be denied service because of my inability to pay.
- I may refuse service at any time.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS: **It is ultimately the client's responsibility to know your coverage and benefits**. You are responsible for any amount not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Some health insurance carriers require the patient to pay a co-pay for services rendered. Payment of the co-pay is expected at the time the service is rendered to the client.

- I authorize the health department (OSDH) to furnish information to my insurance carrier(s) concerning my care.
- I authorize my insurer(s) to pay any benefits directly to the health department. I understand that any amount remaining after such payment has been made by my insurance carrier becomes the client's responsibility.
- I have read the above policy regarding my financial responsibility to the health department for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate.
- I acknowledge that I have received a copy of the *Oklahoma State Department of Health Privacy Statement* as required by the Health Information Portability and Accountability Act (HIPAA). I can also find a copy on the agency website.

CONSENT TO RECEIVE TEXT/EMAILS: The OSDH HIPAA Privacy Notice states that it is my right to accept and/or reject receiving text/emails from the OSDH. By OSDH policy, only appointment reminders, customer surveys and "please contact the office" messages can be sent via SMS texting/email. No lab results or sensitive medical information will be transmitted via text/email. I acknowledge that it is my responsibility to update my contact information with OSDH as needed. I understand that I may opt out of receiving messages at any time by calling the OSDH office.

I authorize the OSDH to send me emails Yes ☐ No ☐ Email address: _____

I authorize the OSDH to send me text messages Yes ☐ No ☐ Cell #: _____

Cell Carrier: _____

_____ _____

Printed Name of Consenter | Relationship to Client (Self/Other – please specify)

_____ _____

Signature of Consenter | Date

_____ _____

Additional Signature (if required) | Date

These messages originate from a secure device but will arrive unencrypted. Your cellphone service provider may charge for delivery of text messages.