



## PRE-PARTICIPATION PHYSICAL EVALUATION FORM AND PARENTAL CONSENT

No student shall be eligible to represent his/her school in athletics or marching band until there is on file with the school a physical examination and parental consent certificate.

All physicals for OSSAA participation must be given no earlier than May 1 of the preceding year in which the students are to participate and before the first day of practice in that student's particular activity. The physical will be valid from the date of the physical given until the next required physical. Parent(s) or guardian(s) must sign the parental consent form each year before the student participates in any organized athletic practice session including contest participation.

The pre-participation evaluation form is designed to identify risk factors prior to participation by way of a thorough medical history and physical examination. A qualified physician, physician's assistant, or an advanced practice nurse covered by professional liability insurance shall give the physical examinations.

1. The most current version of the OSSAA PPE form should be used; any other form used must contain a minimum of the information requested on the OSSAA PPE form.
2. The PPE Form must be signed and completed in its entirety. No pre-signed or pre-stamped forms will be accepted.
3. SIGNATURES
  - ☐ The person administering the PPE's signature must be hand-written and dated. No signature stamps will be accepted.
  - ☐ The parent/guardian signatures must be hand-written and dated.
  - ☐ The student-athlete signature must be hand-written and dated.
4. DISTRIBUTION
  - ☐ History Form retained by Physician/Healthcare Provider
  - ☐ Examination Form and Consent and Release Form signed and returned to member school.
  - ☐ PPE's should be held to HIPPA standards; however school medical personnel and coaches should be aware of any rescue medications or conditions relevant to the student.

# OKLAHOMA SECONDARY SCHOOL ACTIVITIES ASSOCIATION



## PREPARTICIPATION PHYSICAL HISTORY FORM

Students should complete and sign this form (with your parents if younger than 18) before your appointment. History Form is retained by member school and health care provider.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Grade: \_\_\_\_\_

Sex at birth (Female or Male): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie. Medicines, pollens, food, stinging insects). \_\_\_\_\_

Are your required vaccinations current? \_\_\_\_\_

- |    |                                                                                                  | (CIRCLE ONE) |
|----|--------------------------------------------------------------------------------------------------|--------------|
| 1. | Do you feel stressed out or under a lot of pressure?                                             | YES NO       |
| 2. | Do you ever feel sad, hopeless, depressed, or anxious?                                           | YES NO       |
| 3. | Do you feel safe at your home or residence?                                                      | YES NO       |
| 4. | Have you ever tried cigarettes, chewing tobacco, snuff, or dip?                                  | YES NO       |
| 5. | During the last 30 days, did you use chewing tobacco, snuff, or dip?                             | YES NO       |
| 6. | Have you ever taken anabolic steroids or use any other appearance/performance supplement?        | YES NO       |
| 7. | Have you ever taken any supplements to help you gain or lose weight or improve your performance? | YES NO       |

| GENERAL QUESTIONS<br>(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.) | Yes        | No        | HEART HEALTH QUESTIONS ABOUT YOU<br>(CONTINUED)                                                                                                                                                                                                                                                                        | Yes        | No        |
|----------------------------------------------------------------------------------------------------------------------|------------|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| 1. Do you have any concerns that you would like to discuss with your provider?                                       |            |           | 9. Do you get light-headed or feel shorter of breath than your friends during exercise?                                                                                                                                                                                                                                |            |           |
| 2. Has a provider ever denied or restricted your participation in sports for any reason?                             |            |           | 10. Have you ever had a seizure?                                                                                                                                                                                                                                                                                       |            |           |
| 3. Do you have any ongoing medical issues or recent illness?                                                         |            |           | <b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>                                                                                                                                                                                                                                                                        | <b>Yes</b> | <b>No</b> |
| <b>HEART HEALTH QUESTIONS ABOUT YOU</b>                                                                              | <b>Yes</b> | <b>No</b> | 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?                                                                                                                                       |            |           |
| 4. Have you ever passed out or nearly passed out during or after exercise?                                           |            |           | 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic poly-morphic ventricular tachycardia (CPVT)? |            |           |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?                         |            |           | 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?                                                                                                                                                                                                                             |            |           |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?                |            |           |                                                                                                                                                                                                                                                                                                                        |            |           |
| 7. Has a doctor ever told you that you have any heart problems?                                                      |            |           |                                                                                                                                                                                                                                                                                                                        |            |           |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.    |            |           |                                                                                                                                                                                                                                                                                                                        |            |           |

# OKLAHOMA SECONDARY SCHOOL ACTIVITIES ASSOCIATION

| BONE AND JOINT QUESTIONS                                                                                                                       | Yes | No |
|------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? |     |    |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you?                                                                    |     |    |
| MEDICAL QUESTIONS                                                                                                                              | Yes | No |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise?                                                               |     |    |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?                                                     |     |    |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?                                                         |     |    |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?  |     |    |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?                                  |     |    |
| 21. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?  |     |    |
| 22. Have you ever become ill while exercising in the heat?                                                                                     |     |    |
| 23. Do you or does someone in your family have sickle cell trait or disease?                                                                   |     |    |
| 24. Have you ever or do you have any problems with your eyes or vision?                                                                        |     |    |

| MEDICAL QUESTIONS (CONTINUED)                                                        | Yes | No |
|--------------------------------------------------------------------------------------|-----|----|
| 25. Do you worry about your weight?                                                  |     |    |
| 26. Are you trying to or has anyone recommended that you gain or lose weight?        |     |    |
| 27. Are you on a special diet or do you avoid certain types of food and food groups? |     |    |
| 28. Have you ever had an eating disorder?                                            |     |    |
| FEMALES ONLY                                                                         | Yes | No |
| 29. Have you ever had a menstrual period?                                            |     |    |
| 30. How old were you when you had your first menstrual period?                       |     |    |
| 31. When was your most recent menstrual period?                                      |     |    |
| 32. How many periods have you had in the past 12 months?                             |     |    |

**Explain "Yes" answers here.**

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I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: \_\_\_\_\_

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

Date: \_\_\_\_\_

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# OKLAHOMA SECONDARY SCHOOL ACTIVITIES ASSOCIATION

## PHYSICAL EXAMINATION

(Physical examination must be performed on or after May 1 for the following school year.)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ School Name: \_\_\_\_\_

| EXAMINATION                                                                                                                                             |               |                          |                           |                           |                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------|---------------------------|---------------------------|--------------------------|
| Height                                                                                                                                                  |               | Weight                   |                           | Sex at Birth: Male Female |                          |
| BP                                                                                                                                                      | /             | (                        | /                         | )                         | Pulse                    |
| Vision                                                                                                                                                  | R 20/         | L 20/                    | Corrected?                | Y                         | N                        |
| <b>MEDICAL</b>                                                                                                                                          |               |                          |                           | <b>NORMAL</b>             | <b>ABNORMAL FINDINGS</b> |
| Appearance                                                                                                                                              |               |                          |                           |                           |                          |
| Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span height, hyperlaxity, myopia, MVP, aortic insufficiency) |               |                          |                           |                           |                          |
| Eyes/ears/nose/throat                                                                                                                                   |               |                          |                           |                           |                          |
| Pupils equal                                                                                                                                            |               |                          |                           |                           |                          |
| Hearing                                                                                                                                                 |               |                          |                           |                           |                          |
| Lymph nodes                                                                                                                                             |               |                          |                           |                           |                          |
| Heart                                                                                                                                                   |               |                          |                           |                           |                          |
| Murmurs (auscultation standing, supine, +/- Valsalva)                                                                                                   |               |                          |                           |                           |                          |
| Location of point of maximal impulse (PMI)                                                                                                              |               |                          |                           |                           |                          |
| Pulses                                                                                                                                                  |               |                          |                           |                           |                          |
| Simultaneous femoral and radial pulses                                                                                                                  |               |                          |                           |                           |                          |
| Lungs                                                                                                                                                   |               |                          |                           |                           |                          |
| Abdomen                                                                                                                                                 |               |                          |                           |                           |                          |
| Skin                                                                                                                                                    |               |                          |                           |                           |                          |
| HSV, lesions suggestive of MRSA, tinea corporis                                                                                                         |               |                          |                           |                           |                          |
| Neurologic                                                                                                                                              |               |                          |                           |                           |                          |
| <b>MUSCULOSKELETAL</b>                                                                                                                                  |               |                          |                           |                           |                          |
|                                                                                                                                                         | <b>NORMAL</b> | <b>ABNORMAL FINDINGS</b> |                           | <b>NORMAL</b>             | <b>ABNORMAL FINDINGS</b> |
| Neck                                                                                                                                                    |               |                          | Knee                      |                           |                          |
| Back                                                                                                                                                    |               |                          | Leg/ankle                 |                           |                          |
| Shoulder/arm                                                                                                                                            |               |                          | Foot/toes                 |                           |                          |
| Elbow/forearm                                                                                                                                           |               |                          | Functional                |                           |                          |
| Wrist/hand/fingers                                                                                                                                      |               |                          | Duck-walk, single leg hop |                           |                          |
| Hip/thigh                                                                                                                                               |               |                          |                           |                           |                          |

☐ Cleared for all sports without restriction ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_

☐ Not cleared ☐ Pending further evaluation ☐ For any activities

Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the activities outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Health Care Professional (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ License # \_\_\_\_\_

Signature of Health Care Professional \_\_\_\_\_



# OKLAHOMA SECONDARY SCHOOL ACTIVITIES ASSOCIATION

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## PARENT/GUARDIAN CONSENT FORM

*(To be retained by member school with history and parent consent forms)*

STUDENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

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 in/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 STUDENT \_\_\_\_\_ DATE \_\_\_\_\_