OSSAA PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM

PLEASE PRINT

Name ________________________________ Sex ____________________________ Date of Birth ____________________________

Grade ____________________________ School ____________________________ Sport(s) ____________________________

Address ________________________________ Phone ____________________________

Personal physician ____________________________ Phone ____________________________

In case of emergency, contact: Name ____________________________ Phone ____________________________

Relationship ____________________________ Phone (H) ____________________________ (W) ____________________________

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

1. Have you had a medical illness or injury since your last check up or sports physical?
   Yes ☐ No ☐

   Do you have an ongoing or chronic illness?
   Yes ☐ No ☐

2. Have you ever been hospitalized overnight?
   Yes ☐ No ☐

   Have you ever had surgery?
   Yes ☐ No ☐

3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?
   Yes ☐ No ☐

   Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
   Yes ☐ No ☐

4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?
   Yes ☐ No ☐

   Have you ever had a rash or hives develop during or after exercise?
   Yes ☐ No ☐

5. Have you ever passed out during or after exercise?
   Yes ☐ No ☐

   Have you ever been dizzy during or after exercise?
   Yes ☐ No ☐

6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?
   Yes ☐ No ☐

7. Have you ever had a head injury or concussion?
   Yes ☐ No ☐

   Have you ever been knocked out, become unconscious, or lost your memory?
   Yes ☐ No ☐

   Have you ever had a seizure?
   Yes ☐ No ☐

   Do you have frequent or severe headaches?
   Yes ☐ No ☐

   Have you ever had numbness or tingling in your arms, hands, legs, or feet?
   Yes ☐ No ☐

8. Have you ever become ill from exercising in the heat?
   Yes ☐ No ☐

   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.

Signature of parent/guardian ____________________________ Date ____________________________

Signature of athlete ____________________________

(Complete Back Side)
# PREPARTICIPATION PHYSICAL EVALUATION

**PLEASE PRINT**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

**DATE OF EXAM**

**Height** | **Weight** | **Body fat (optional)** | **Pulse** | **BP** | **Initial BP** | **Post Exercise** | **5 Min. Post Ex.** |
|----------|------------|-------------------------|-----------|--------|--------------|------------------|------------------|

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

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**MEDICAL**

<table>
<thead>
<tr>
<th>Medical Category</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/Ears/Throat</td>
<td></td>
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<tr>
<td>Lymph Nodes</td>
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<td>Heart</td>
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<tr>
<td>Pulses</td>
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<tr>
<td>Lungs</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Genitalia (male only)</td>
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<td></td>
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<tr>
<td>Skin</td>
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<tr>
<td>MUSCULOSKETAL</td>
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</tr>
<tr>
<td>Neck</td>
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<tr>
<td>Back</td>
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<tr>
<td>Shoulder/Arm</td>
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<td>Elbow/Forearm</td>
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<tr>
<td>Wrist/Hand</td>
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<tr>
<td>Hip/Thigh</td>
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<tr>
<td>Knee</td>
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<tr>
<td>Leg/Ankle</td>
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<tr>
<td>Foot</td>
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</tbody>
</table>

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**CLEARANCE**

(  ) Cleared

(  ) Cleared after completing evaluation/rehabilitation for:  

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(  ) Not cleared for: ______________________  Reason: ______________________

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**Recommendations:**

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**Name & Title of Examiner (Print/Type)______________________**  **Date________________****

**Address_________________________**  **Phone______________________**

**Signature of Examiner_______________________________**