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 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 (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	**Yes**	**No**
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
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.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	**Yes**	**No**
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
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)?		
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)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

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?	(Age)	
31. When was your most recent menstrual period?	(Date)	
32. How many periods have you had in the past 12 months?	(Number)	

Explain "Yes" answers here.

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: _____

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		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
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		

MUSCULOSKELETAL

	NORMAL	ABNORMAL FINDINGS		NORMAL	ABNORMAL FINDINGS
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 _____

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_____