

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

Students Name _____ Birth Date _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____ / _____, _____ / _____, _____ / _____

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

Follow-Up Questions on More Sensitive Issues (Optional)

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Questions from the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.

Notes: _____

MEDICAL	Normal	Abnormal findings	Initials*
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

Notes: _____

Clearance

Cleared without restriction

Cleared, with recommendations for further evaluation or treatment for:

Not cleared for: All Sports Certain sports: Reason: Recommendations:

Emergency Information:

Allergies: _____
 Other Information: _____
 Name of Physician: (print/type/stamp) _____ (M.D., D.O., D.C.) Date: _____

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

Address: _____ Phone: _____

Signature of Physician: _____ Date: _____



OHSAA AUTHORIZATION FORM

I hereby authorize the release and disclosure of the personal health information of _____ ("Student"), as described below, to _____ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: _____

School Address: _____

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

Student's Signature Birth date of Student, including year


Name of Student's personal representative, if applicable
I am the Student's (check one): _____ Parent _____ Legal Guardian (documentation must be provided)


Signature of Student's personal representative, if applicable Date

A copy of this signed form has been provided to the student or his/her personal representative
THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL

2011-2012 Ohio High School Athletic Association Eligibility and Authorization Statement


This document is to be signed by the participant from an OHSAA member school and by the participant's parent.


 I have read, understand and acknowledge receipt of the OHSAA brochure entitled "Your Athletic Eligibility," which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the *OHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the *Handbook* are also posted on the OHSAA web site at www.ohsaa.org.


 I understand that an OHSAA member school must adhere to all rules and regulations that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.


 I understand that participation in interscholastic athletics is a privilege not a right.


Student Code of Responsibility


 As a student athlete, I understand and accept the following responsibilities:


 I will respect the rights and beliefs of others and will treat others with courtesy and consideration


 I will be fully responsible for my own actions and the consequences of my actions


 I will respect the property of others


 I will respect and obey the rules of my school and laws of my community, state and country


 I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state and country


 I understand that a student whose character or conduct violates the school's Athletic Code or School Code of Conduct is not in good standing and is ineligible for a period of time as determined by the principal


 **Informed Consent** – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**


 I understand that in the case of injury or illness requiring transportation to a health care facility, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.

 To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school I consent to the release to the OHSAA any and all portions of school record files, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work completed, grades received and attendance data.

 I consent to the OHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

 I understand that if I drop a class, take course work through Post Secondary Enrollment Option, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility.

 I understand all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a competition due to a suspected concussion, he or she will be unable to return to competition that day without the written authorization from a physician (M.D. or D.O.) or an athletic trainer which indicates that the student has not been concussed. Further, I acknowledge that discussion took place and materials were provided to me on this topic by my school.

 By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.

Must Be Signed Before Physical Examination

Student's Signature	Birth date	Grade in School	Date
---------------------	------------	-----------------	------

Parent's or Guardian's Signature	Date
----------------------------------	------

2011-12

STUDENT NAME _____ **DATE** _____
(Last Name, First Name- Please Print)

**LEBANON CITY SCHOOLS
INTERSCHOLASTIC ATHLETIC
CODE OF CONDUCT/HANDBOOK**

I am or will be a student-athlete as defined by the Interscholastic Athletic Code of Conduct/Handbook. **I have read the Code of Conduct and Handbook either hardcopy or online and understand that I will be subject to abide by the following rules in the Code of Conduct/Handbook while enrolled as a student in the Lebanon City Schools.** This Code of Conduct/Handbook shall govern me as a student-athlete for all athletic seasons during the 2011-12 school year.

ATHLETE SIGNATURE _____ **DATE** _____

I, parent/legal guardian of the above signed student-athlete, hereby grant him/her permission to participate in the athletic program of the Lebanon City Schools under the Interscholastic Athletic Code of Conduct/Handbook. This Code of Conduct/Handbook shall govern this student-athlete for all athletic seasons during the 2011-12 school years.

I have read the Student-Athlete handbook either hardcopy or online.

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

ACKNOWLEDGMENT OF WARNING BY STUDENT

I hereby acknowledge that I have been properly advised, cautioned and warned by the personnel of the Lebanon City School District that by participating in sports and/or extracurricular activities, I am exposing myself to the risk of serious injury, including but not limited to, the risk of sprains, fractures and ligaments and/or cartilage damage which could result in a temporary or permanent, partial or complete, impairment in the use of my limbs; brain damage; paralysis; or even death. Having been so cautioned and warned, it is still my desire to participate in sports and/or extracurricular activities, I hereby further acknowledge that I do so with full knowledge and understanding of the risk of serious injury to which I am exposing myself by participating in the sport and/or extracurricular activity.

ATHLETE SIGNATURE _____ **DATE** _____

ACKNOWLEDGMENT OF WARNING BY PARENTS

We/I the parents of the above mentioned student, do hereby acknowledge that we/I have been fully advised, cautioned and warned by the proper school personnel of the Lebanon City School District that our/my child named above may suffer serious injury, including but not limited to sprains, fractures, brain damage, paralysis or even death, by participating in sports and/or extracurricular activities. Notwithstanding such warnings, and with full knowledge and understanding of the risk of serious injury to our/my child named above which may result, we/I give our consent to participate in sports and/or extracurricular activities.

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____



EMERGENCY MEDICAL AUTHORIZATION FORM

School _____ Student Name _____

Grade _____ Gender _____ Address _____

Telephone _____

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. **Information provided on this form will be shared with school personnel who interact with your child to ensure his/her safety at school unless you note otherwise.**

Residential (lives with) Parent or Guardian:

(Designate – work or home)

Mother’s Name _____ Daytime Phone _____

Father’s Name _____ Daytime Phone _____

Guardian’s Name _____ Daytime Phone _____

Name of (Local) Relative or Childcare Provider (circle one):

Phone _____

Address _____

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____

Preferred Local Hospital _____ Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctor, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

IMPORTANT

Please list any facts concerning the child’s medical history including allergies, medications being taken, current medical conditions, and any physical impairments to which the school and a physician should be alerted.

Date _____

Signature of Parent/Guardian _____

PART II – REFUSAL TO CONSENT

I do not give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Date _____

Signature of Parent/Guardian _____

PROOF OF RESIDENCY

In accordance with the Ohio High School Athletic Association By-Law 4-6, a student athlete must reside in the Lebanon City School District in order to be eligible to participate in athletics. **Please Print.**

Student-Athlete Information

FIRST/LAST NAME: _____ Gender (M/F): _____

ADDRESS: _____

Parent/Guardian Information

FIRST/LAST NAME: _____

ADDRESS: _____

YES/NO

1. Were you a student in the Lebanon City School District during the past school year? _____

If No, where did you attend school? _____

2. Are you currently residing at your address with the custodial parent/guardian? _____

3. Has your custodial parent/guardian moved from the Lebanon City School District and left you behind to attend a Lebanon City School District school? _____

4. Have you ever been enrolled in another school other than a Lebanon City School? _____

If yes, please list the school(s) you attended and the dates of attendance:

Warning: If a student participates in an athletic contest and his or her eligibility has been established by falsified information (includes but is not limited to: name, address, transcripts, birth certificate, etc.), the student shall be ineligible in Ohio for a maximum of one year from the date the penalty is imposed. (OHSAA By-Law 4-1-2)

Affirmation: I attest that all the information listed above is accurate and truthful.

Student-Athlete Signature: _____ Date: _____