



THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

- 1. Type of disability
- 2. Date of disability
- 3. Classification (if available)
- 4. Cause of disability (birth, disease, accident/trauma, other)
- 5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device or prosthetic?		
7. Do you use a special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you have any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Splina blide		
Latex allergy		

Explain "yes" answers here

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

Signature of Student _____ Signature of parent/guardian _____ Date: _____



PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet or use condoms?
 - Do you consume energy drinks?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (/)	Pulse _____	Vision R 20/ _____ L20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> 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 the point of maximal impulse (PMI)		
Pulses Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional Duck walk, single leg hop		

*Consider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
 †Consider GU exam if in private setting. Having third part present is recommended.
 ‡Consider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

CLEARANCE FORM

Note: Authorization forms (pages 5 and 6) must be signed by both the parent/guardian and the student.

Name _____ Sex M F Age _____ Date of birth _____

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 sports

For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The student does not present apparent clinical contraindication to practice and participate in the sport(s) as 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. In the event that the examination is conducted en masse at the school, the school administrator shall retain a copy of the PPE. If conditions arise after the student 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 physician or medical examiner (print/type) _____ Date of Exam _____

Address _____ Phone _____

Signature of physician/medical examiner _____ MD, DO, D.C., P.A. or A.N.

EMERGENCY INFORMATION

Personal Physician _____ Phone _____

In case of Emergency, contact _____ Phone _____

Allergies _____

Other Information _____

LISBON EXEMPTED VILLAGE SCHOOL DISTRICT
317 NORTH MARKET STREET
LISBON, OH 44432

LISBON DAVID ANDERSON JR-SR HIGH SCHOOL
ATHLETIC ASSOCIATION

TO WHOM IT MAY CONCERN:

This is to inform the Lisbon School District that our son/daughter
_____ is fully covered by our family hospitalization plan.

(Student's Full Name)

We request that he/she not be required to participate in the school adopted extra curricular
accident insurance.

Our family hospitalization is:

(Full Name of Insurance Company)

(Street Address)

(City)

(State)

(Zip)

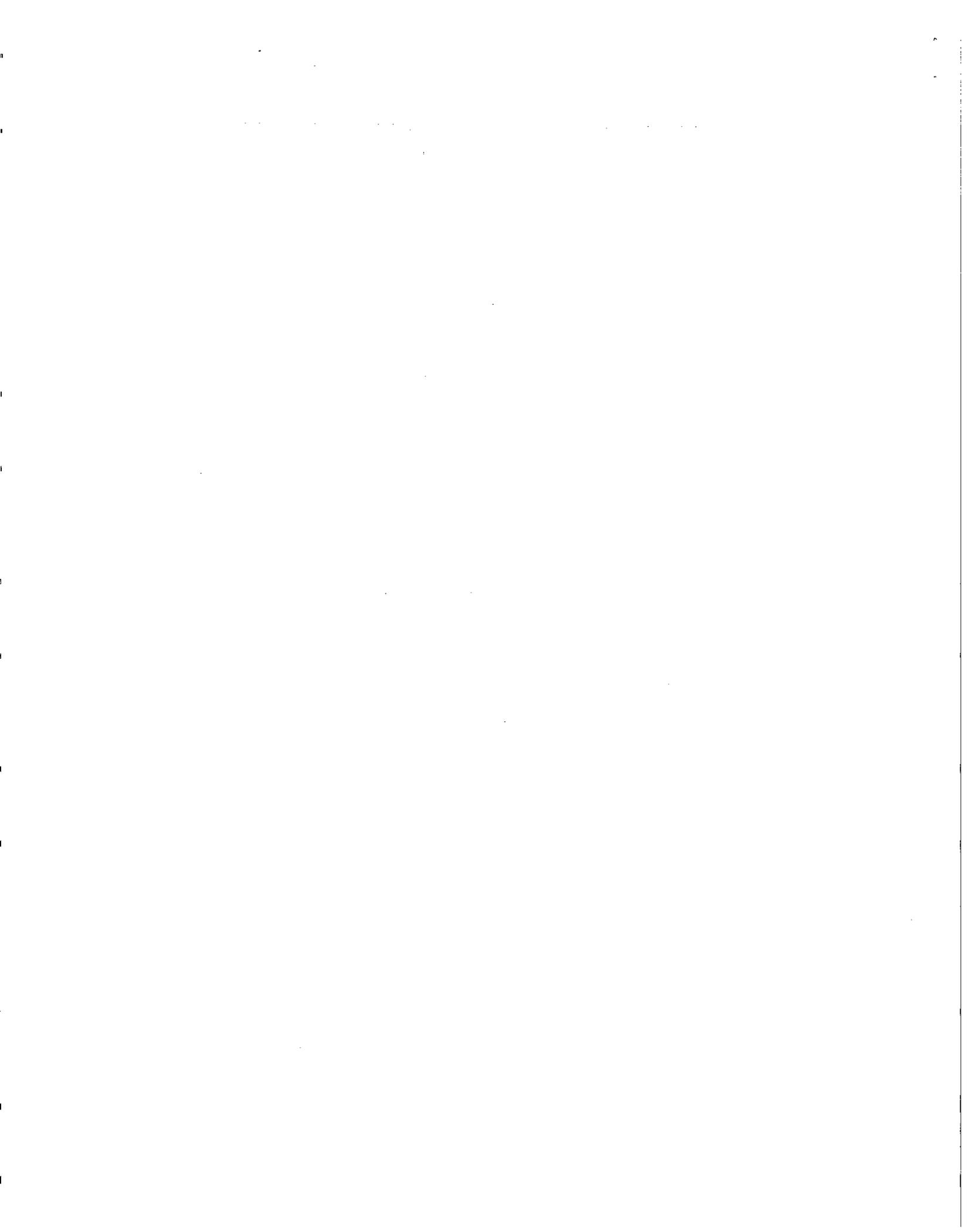
This statement relieves the Lisbon Exempted Village Board of Education and the Athletic
Association of all responsibility in the event of an injury to our child. If for any reason the
aforementioned family hospitalization insurance coverage on our child should terminate, we shall
notify immediately in writing the principal of the high school.

(Parent/Guardian Signature)

(Street Address)

(City)

(Phone Number) (Work Number)



THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL



OHSAA AUTHORIZATION FORM 2012-2013

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 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

2012-2013 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 Responsibility 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.

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

EMERGENCY MEDICAL AUTHORIZATION

LISBON EXEMPTED SCHOOL DISTRICT

DAVID ANDERSON JR/SR HIGH SCHOOL

Grade _____

M F

Student's Name _____

Sex _____

Birth Date _____

MCKINLEY ELEMENTARY SCHOOL

Grade _____ Teacher _____

Address _____

City/State/Zip _____

CHECK IF DIFFERENT ADDRESS FROM LAST YEAR.

Please notify the school of any change in address or phone numbers during the year!

PURPOSE: TO ENABLE PARENTS AND GUARDIANS TO AUTHORIZE THE PROVISION OF EMERGENCY TREATMENT AND TRANSPORTATION OF STUDENTS WHO BECOME ILL OR INJURED WHILE UNDER SCHOOL AUTHORITY, WHEN PARENTS OR GUARDIANS CANNOT BE REACHED.

PART I OR II MUST BE COMPLETED

PART I - GRANT CONSENT

In the event the designated preferred practitioner is not available then treatment by another licensed physician or dentist is granted. In the event that the preferred hospital is not accessible then the nearest accessible hospital is preferred. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent or Guardian _____

Address _____

Date _____

In the event reasonable attempts to contact me/us:

Mother's Name or Legal Guardian _____

Home Phone _____

Work Phone _____

Cell, Pager, Voice Mail _____

Father's Name or Legal Guardian _____

Home Phone _____

Work Phone _____

Cell, Pager, Voice Mail _____

Name of closest relative & relationship _____

Home Phone _____

Work Phone _____

Cell, Pager, Voice Mail _____

Name of friend/neighbor _____

Home Phone _____

Work Phone _____

Cell, Pager, Voice Mail _____

IF ALL THESE ATTEMPTS HAVE BEEN UNSUCCESSFUL, I HEREBY GIVE MY CONSENT FOR ADMINISTRATION OF ANY TREATMENT DEEMED NECESSARY BY:

Preferred Doctor _____

Phone _____

Preferred Dentist _____

Phone _____

Preferred Hospital _____

Facts concerning the child's medical history including allergies, medications being taken, medical conditions, and any physical impairments to which a physician and the school should be alerted:

PART II - REFUSAL TO CONSENT

Signature of Parent or Guardian _____

Address _____

Date _____

I do not give my 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 no action or to:

