

OSSAA PHYSICAL EXAMINATION FORM

PLEASE PRINT

DATE OF EXAM _____

Name _____ **Sex** _____ **Age** _____ **Date of Birth** ____/____/____

Grade _____ **School** _____ **Social Security Number** _____

Address _____ **Phone** _____

Personal Physician _____ **Phone** _____

In case of Emergency, contact: Name _____

Relationship _____ **Phone (H)** _____ **(W)** _____ **(C)** _____

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

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have an ongoing or chronic illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any food allergies (for example, to pollen, medicine, food, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pains during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|---|----------------------------------|------------------------------------|
| 8. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have seasonal allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you use any protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had a sprain, strain, or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, check appropriate box below | | |
| <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/Calf |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Upper Arm | | <input type="checkbox"/> Foot |
| 13. Do you want to weigh more or less than you do right now? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Record the dates of your most recent immunizations (shots) for? | | |
| Tetanus _____ | Measles _____ | |
| Hepatitis _____ | Chickenpox _____ | |

Explain "YES" answers here _____

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 _____ DATE _____

(COMPLETE BACK SIDE)

PREPARTICIPATION PHYSICAL EVALUATION

PLEASE PRINT

DATE OF EXAM _____

Name _____ Date of Birth _____

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 _____

MEDICAL

Normal

Abnormal Findings

	Normal	Abnormal Findings
Appearance		
Eyes/Ears/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (male only)		
Skin		

MUSCULOSKELETAL

Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE

() Cleared

() Cleared after completing evaluation/rehabilitation for: _____

() Not Cleared for: _____ Reason: _____

Recommendations: _____

Name & Title of Examiner (Print/Type) _____ Date _____

Address _____ Phone _____

Signature of Examiner _____

INSURANCE INFORMATION – Must be completed by parents

I understand that any student attending and participating in any school activity at Mangum Public Schools must be covered by accident insurance.

My child/student: _____

(Must list Provider and #) Insurance Provider _____ Policy ID Number _____

(Please check one) _____ Is covered by the school insurance plan. _____ Is covered by family/other insurance plan.

Thereby meeting this insurance requirement; my permission is hereby given to Mangum Public Schools to seek out emergency medical aid for my child if deemed necessary while participating, traveling to and from, or in attendance at any Mangum School activity or function.

Signature of Parent or Guardian