

PHYSICAL DAY

Monday, May 6, 2019

SPONSORED BY: BENJAMIN LOGAN ATHLETIC BOOSTERS

*****During the School Day*****

Student-Athletes Grades 6th-11th will be transported to the Mary Rutan Health Center located at 1134 N Main Street, Bellefontaine by **SCHOOL TRANSPORTATION** on Monday, May 6, 2019. For students to participate in this program, they will be required to utilize **SCHOOL TRANSPORTATION** both to and from the Health Center. This will be conducted during the normal school day to allow students this opportunity to have their physical completed for the 2019-2020 school year.

Below is the schedule we will follow per grade level:

- 8th Grade – depart 8:15am from school
- 7th Grade – depart 9:15am from school
- 11th Grade – depart 10:15am from school
- 6th Grade – depart 11:15am from school
- 9th Grade – depart 12:15pm from school
- 10th Grade – depart 1:15pm from school

Here is what you need to do as a Parent/Guardian:

- 1) Complete the Form and Return
 - Physical packet must be **COMPLETED and SIGNED** in order to participate. **BE SURE TO SIGN ALL HIGHLIGHTED AREAS.**
 - **MUST complete the waiver below for school transportation.**
- 2) The cost is \$15 and must be turned in with completed form.
 - Cash or Check – to Benjamin Logan Athletic Boosters
- 3) You must complete and return the bottom portion of this sheet for school transportation purposes. Only the first 50 students in each grade will be able to attend this event.
- 4) **Forms are to be turned into the Middle School and High School Offices no later than Wed., May 1st.**
If you have any questions or concerns please contact the High School Office at 937-592-1666.

I, the parent/guardian of _____, hereby give permission for my child to attend Physical Day at Mary Rutan Health Center. I understand that my child will be **transported by the Benjamin Logan Transportation Department**. By signing below I am granting permission for my child to be transported to Physical Day on Monday, May 6, 2019.

X

Signature of Parent/Guardian

Please Print Name Here

Date



PREPARTICIPATION PHYSICAL EVALUATION 2019-2020

HISTORY FORM - Please be advised that this paper form is no longer the OHSAA standard.

(Note: This form is to be filled out by the student and parent prior to seeing the medical examiner.)

Date of Exam, Name, Sex, Age, Grade, School, Date of birth, Sport(s), Address, Emergency Contact, Relationship, Phone (H), (W), (Cell), (Email)

Medicines and Allergies: Please list the prescription and over-the-counter medicines and supplements (herbal and nutritional-including energy drinks/ protein supplements) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

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

GENERAL QUESTIONS 1-21. 1. Has a doctor ever denied or restricted your participation in sports for any reason? 2. Do you have any ongoing medical conditions? 3. Have you ever spent the night in the hospital? 4. Have you ever had surgery? 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? 7. Does your heart ever race or skip beats (irregular beats) during exercise? 8. Has a doctor ever told you that you have any heart problems? 9. Has a doctor ever ordered a test for your heart? 10. Do you get lightheaded or feel more short of breath than expected during exercise? 11. Have you ever had an unexplained seizure? 12. Do you get more tired or short of breath more quickly than your friends during exercise? 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50? 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game? 18. Have you ever had any broken or fractured bones or dislocated joints? 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? 20. Have you ever had a stress fracture? 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)

22. Do you regularly use a brace, orthotics, or other assistive device? 23. Do you have a bone, muscle, or joint injury that bothers you? 24. Do any of your joints become painful, swollen, feel warm, or look red? 25. Do you have any history of juvenile arthritis or connective tissue disease?

26. Do you cough, wheeze, or have difficulty breathing during or after exercise? 27. Have you ever used an inhaler or taken asthma medicine? 28. Is there anyone in your family who has asthma? 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? 30. Do you have groin pain or a painful bulge or hernia in the groin area? 31. Have you had infectious mononucleosis (mono) within the past month? 32. Do you have any rashes, pressure sores, or other skin problems? 33. Have you had a herpes (cold sores) or MRSA (staph) skin infection? 34. Have you ever had a head injury or concussion? 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems? 36. Do you have a history of seizure disorder or epilepsy? 37. Do you have headaches with exercise? 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? 39. Have you ever been unable to move your arms or legs after being hit or falling? 40. Have you ever become ill while exercising in the heat? 41. Do you get frequent muscle cramps when exercising? 42. Do you or someone in your family have sickle cell trait or disease? 43. Have you had any problems with your eyes or vision? 44. Have you had an eye injury? 45. Do you wear glasses or contact lenses? 46. Do you wear protective eyewear, such as goggles or a face shield? 47. Do you worry about your weight? 48. Are you trying to gain or lose weight? Has anyone recommended that you do? 49. Are you on a special diet or do you avoid certain types of foods? 50. Have you ever had an eating disorder? 51. Do you have any concerns that you would like to discuss with a doctor? 52. Have you ever had a menstrual period? 53. How old were you when you had your first menstrual period? 54. How many periods have you had in the last 12 months?

Explain "yes" answers here

Blank lines for explaining "yes" answers.

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

The student has family insurance Yes No If yes, family insurance company name and policy number:



PREPARTICIPATION PHYSICAL EVALUATION 2019-2020
THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

PLEASE COMPLETE ONLY IF YOUR STUDENT HAS SPECIAL NEEDS OR A DISABILITY.

Date of Exam _____ Name _____ Date of birth _____
Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Table with 16 rows of questions regarding disabilities and medical history. Questions include: 1. Type of disability, 2. Date of disability, 3. Classification, 4. Cause of disability, 5. List the sports you are interested in playing, 6-16. Do you regularly use a brace, assistive device or prosthetic? Do you use a special brace or assistive device for sports? Do you have any rashes, pressure sores, or any other skin problems? Do you have a hearing loss? Do you use a hearing aid? Do you have a visual impairment? Do you have any special devices for bowel or bladder function? Do you have burning or discomfort when urinating? Have you had autonomic dysreflexia? Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia) illness? Do you have muscle spasticity? Do you have frequent seizures that cannot be controlled by medication?

Explain "yes" answers here

Blank lines for explaining "yes" answers to the previous table.

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

Table with 18 rows of conditions and two columns for 'Yes' and 'No'. Conditions include: 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, Spina bifida, Latex allergy.

Explain "yes" answers here

Blank lines for explaining "yes" answers to the previous table.

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

- 1. 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?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

Table with columns: EXAMINATION, DATE OF EXAMINATION, Height, Weight, Male/Female, BP, Pulse, Vision R 20/L20, Corrected Y/N, MEDICAL, ABNORMAL FINDINGS. Rows include: Appearance, Eyes/ears/nose/throat, Lymph nodes, Heart, Pulses, Lungs, Abdomen, Genitourinary (males only), Skin, Neurologic, MUSCULOSKELETAL, Neck, Back, Shoulder/arm, Elbow/forearm, Wrist/hand/fingers, Hip/thigh, Knee, Leg/ankle, Foot/toes, Functional.

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

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 2019-2020

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

PREPARTICIPATION PHYSICAL EVALUATION 2019-2020
2019-2020 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 Student Eligibility Guide and Checklist** <https://www.ohsaa.org/Portals/0/Eligibility/OtherEligibilityDocs/EligibilityGuideHS.pdf> 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 website at 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 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 treatment by medical personnel and 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 treated and transported via ambulance to the nearest hospital.


 I **consent to medical treatment** for the student following an injury or illness suffered during practice and/or a contest.


 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 College Credit Plus, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility. I **accept full responsibility** for compliance with Bylaw 4-4-1, Scholarship, and the passing five credit standard expressed therein.

 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 practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required in order for the student to return to participation.

 I have read and signed the Ohio Department of Health's **Concussion Information Sheet** and have retained a copy for myself.

 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