

# 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): \_\_\_\_\_ Activity(ies) \_\_\_\_\_

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.)			HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
	Yes	No			
1. Do you have any concerns that you would like to discuss with your provider?			9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
2. Has a provider ever denied or restricted your participation in sports for any reason?			10. Have you ever had a seizure?		
3. Do you have any ongoing medical issues or recent illness?			HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
HEART HEALTH QUESTIONS ABOUT YOU	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)?	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?			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)?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
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.					

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?		
COMMENTS: (NOT REQUIRED)		

Explain "Yes" answers here.

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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: \_\_\_\_\_

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## 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	
<b>MEDICAL</b>				<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>
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 \_\_\_\_\_

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UPDATED APRIL 2025

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## 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 \_\_\_\_\_