Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2016-2017

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 _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ 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		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		
2.	Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections Other: _____		
3.	Have you ever spent the night in the hospital?		
4.	Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU		**Yes**	**No**
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? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9.	Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
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?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		**Yes**	**No**
13.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14.	Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arryhthmogenic 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?		
BONE AND JOINT QUESTIONS		**Yes**	**No**
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)		

BONE AND JOINT QUESTIONS - CONTINUED		Yes	No
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?		

MEDICAL QUESTIONS		Yes	No
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?		
FEMALES ONLY			
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

_____

_____

_____

_____

_____

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: _____

Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2016-2017

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) _____

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		
Spina bifida		
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

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).

EXAMINATION		DATE OF EXAMINATION _____
Height	Weight	☐ Male ☐ Female
BP / (/)	Pulse	Vision R 20/ L20/ Corrected ☐ Y ☐ 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		

[a]Consider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third part present is recommended.
[c]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 pre-participation physical evaluation. The student does not present apparent clinical contraindications 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.P.

EMERGENCY INFORMATION

Personal Physician _____ Phone _____

In case of Emergency, contact _____ Phone _____

Allergies _____

_____

_____

_____

_____

_____

Other Information _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PREPARTICIPATION PHYSICAL EVALUATION 2016-2017

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 2016-2017

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

<u>A copy of this signed form has been provided to the student or his/her personal representative</u>

PREPARTICIPATION PHYSICAL EVALUATION 2016-2017

2016-2017 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 Athlete Eligibility Guide** 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

Ohio Department of Health Concussion Information Sheet

For Interscholastic Athletics

Dear Parent/Guardian and Athletes,

This information sheet is provided to assist you and your child in recognizing the signs and symptoms of a concussion. Every athlete is different and responds to a brain injury differently, so seek medical attention if you suspect your child has a concussion. Once a concussion occurs, it is very important your athlete return to normal activities slowly, so he/she does not do more damage to his/her brain.

What is a Concussion?

A concussion is an injury to the brain that may be caused by a blow, bump, or jolt to the head. Concussions may also happen after a fall or hit that jars the brain. A blow elsewhere on the body can cause a concussion even if an athlete does not hit his/her head directly. Concussions can range from mild to severe, and athletes can get a concussion even if they are wearing a helmet.

Signs and Symptoms of a Concussion

Athletes do not have to be "knocked out" to have a concussion. In fact, less than 1 out of 10 concussions result in loss of consciousness. Concussion symptoms can develop right away or up to 48 hours after the injury. Ignoring any signs or symptoms of a concussion puts your child's health at risk!

Signs Observed by Parents of Guardians

- *Appears dazed or stunned.*
- *Is confused about assignment or position.*
- *Forgets plays.*
- *Is unsure of game, score or opponent.*
- *Moves clumsily.*
- *Answers questions slowly.*
- *Loses consciousness (even briefly).*
- *Shows behavior or personality changes (irritability, sadness, nervousness, feeling more emotional).*
- *Can't recall events before or after hit or fall.*

Symptoms Reported by Athlete

- *Any headache or "pressure" in head. (How badly it hurts does not matter.)*
- *Nausea or vomiting.*
- *Balance problems or dizziness.*
- *Double or blurry vision.*
- *Sensitivity to light and/or noise*
- *Feeling sluggish, hazy, foggy or groggy.*
- *Concentration or memory problems.*
- *Confusion.*
- *Does not "feel right."*
- *Trouble falling asleep.*
- *Sleeping more or less than usual.*

Be Honest

Encourage your athlete to be honest with you, his/her coach and your health care provider about his/her symptoms. Many young athletes get caught up in the moment and/or feel pressured to return to sports before they are ready. It is better to miss one game than the entire season… or risk permanent damage!

Seek Medical Attention Right Away

Seeking medical attention is an important first step if you suspect or are told your child has a concussion. A qualified health care professional will be able to determine how serious the concussion is and when it is safe for your child to return to sports and other daily activities.

- *No athlete should return to activity on the same day he/she gets a concussion.*
- *Athletes should NEVER return to practices/games if they still have ANY symptoms.*
- *Parents and coaches should never pressure any athlete to return to play.*

The Dangers of Returning Too Soon

Returning to play too early may cause Second Impact Syndrome (SIS) or Post-Concussion Syndrome (PCS). SIS occurs when a second blow to the head happens before an athlete has completely recovered from a concussion. This second impact causes the brain to swell, possibly resulting in brain damage, paralysis, and even death. PCS can occur after a second impact. PCS can result in permanent, long-term concussion symptoms. The risk of SIS and PCS is the reason why no athlete should be allowed to participate in any physical activity before they are cleared by a qualified health care professional.

Recovery

A concussion can affect school, work, and sports. Along with coaches and teachers, the school nurse, athletic trainer, employer, and other school administrators should be aware of the athlete's injury and their roles in helping the child recover.

During the recovery time after a concussion, physical and mental rest are required. A concussion upsets the way the brain normally works and causes it to work longer and harder to complete even simple tasks. Activities that require concentration and focus may make symptoms worse and cause the brain to heal slower. Studies show that children's brains take several weeks to heal following a concussion.

OHIO INJURY PREVENTION PARTNERSHIP

www.healthyohioprogram.org/concussion

Rev. 02.13

What is a Concussion?

1. Be sure your child gets plenty of rest and enough sleep at night – no late nights. Keep the same bedtime weekdays and weekends.
2. Encourage daytime naps or rest breaks when your child feels tired or worn-out.
3. Limit your child's activities that require a lot of thinking or concentration (including social activities, homework, video games, texting, computer, driving, job-related activities, movies, parties). These activities can slow the brain's recovery.
4. Limit your child's physical activity, especially those activities where another injury or blow to the head may occur.
5. Have your qualified health care professional check your child's symptoms at different times to help guide recovery.

Returning to School

1. Your athlete may need to initially return to school on a limited basis, for example for only half-days, at first. This should be done under the supervision of a qualified health care professional.
2. Inform teacher(s), school counselor or administrator(s) about the injury and symptoms. School personnel should be instructed to watch for:
   a. Increased problems paying attention.
   b. Increased problems remembering or learning new information.
   c. Longer time needed to complete tasks or assignments.
   d. Greater irritability and decreased ability to cope with stress.
   e. Symptoms worsen (headache, tiredness) when doing schoolwork.
3. Be sure your child takes multiple breaks during study time and watch for worsening of symptoms.
4. If your child is still having concussion symptoms, he/she may need extra help with school-related activities. As the symptoms decrease during recovery, the extra help or supports can be removed gradually.

Resources

ODH Violence and Injury Prevention Program
www.healthyohioprogram.org/vipp/injury.aspx

Centers for Disease Control and Prevention
www.cdc.gov/Concussion

National Federation of State High School Associations
www.nfhs.org

Brain Injury Association of America
www.biausa.org/

Returning to Play

1. Returning to play is specific for each person, depending on the sport. *Ohio law requires written permission from a health care provider before an athlete can return to play.* Follow instructions and guidance provided by a health care professional. It is important that you, your child and your child's coach follow these instructions carefully.
2. Your child should NEVER return to play if he/she still has ANY symptoms. (Be sure that your child does not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration).
3. Be sure that the athletic trainer, coach and physical education teacher are aware of your child's injury and symptoms.
4. Your athlete should complete a step-by-step exercise -based progression, under the direction of a qualified healthcare professional.
5. A sample activity progression is listed below. Generally, each step should take no less than 24 hours so that your child's full recovery would take about one week once they have no symptoms at rest and with moderate exercise.*

Sample Activity Progression*

Step 1: *Low levels of non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: walking, light jogging, and easy stationary biking for 20-30 minutes).*

Step 2: *Moderate, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: moderate jogging, brief sprint running, moderate stationary biking, light calisthenics, and sport-specific drills without contact or collisions for 30-45 minutes).*

Step 3: *Heavy, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: extensive sprint running, high intensity stationary biking, resistance exercise with machines and free weights, more intense non-contact sports specific drills, agility training and jumping drills for 45-60 minutes).*

Step 4: *Full contact in controlled practice or scrimmage.*

Step 5: *Full contact in game play.*

***If any symptoms occur, the athlete should drop back to the previous step and try to progress again after a 24 hour rest period.**

Ohio Department of Health
Violence and Injury Prevention Program
246 North High Street, 8th Floor
Columbus, OH 43215
(614) 466-2144

www.healthyohioprogram.org/concussion

Rev. 02.13

Ohio Department of Health Concussion Information Sheet

For Interscholastic Athletics

I have read the Ohio Department of Health's Concussion Information Sheet and understand that I have a responsibility to report my/my child's symptoms to coaches, administrators and health care provider.

I also understand that I/my child must have no symptoms before return to play can occur.

_____ _____

Athlete Date

_____

Athlete

Please print name

Rev. 01.13

_____ _____

Parent/Guardian Date

Signature

_____

Parent/Guardian

Please print name

TOLEDO PUBLIC SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION

Student Name _____ School _____ H.R. _____

Address _____ Home Phone _____

SS# _____

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.

Pertinent medical information may be shared with appropriate school personnel

Residential Parent/Guardian:

Mother's Name _____ Daytime Phone _____

Father's Name _____ Daytime Phone _____

Other's Name _____ Daytime Phone _____

Name of Relative or Childcare provider: _____ Relationship _____

Address: _____ Phone _____

(PART I OR PART 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 _____

Medical specialist _____ Phone _____

Local hospital _____ Emergency Rm. 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 above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably 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.

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

_____

Date _____ Signature of Parent/Guardian _____ Address _____

(DO NOT COMPLETE PART II IF COMPLETED PART I) – PART II - REFUSAL TO CONSENT

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 the following action: _____

Date _____ Signature of Parent/Guardian _____ Address _____