2018-19
Logan Elm Athletic Forms

Student Name

Please complete the following forms and return them ALL together as a packet.

IMPORTANT NOTES:

- Be sure to sign and date all forms.
- All forms last one year from doctor’s signature and date.
- Along with these forms you must also attend one OHSAA Parent Meeting a year prior to the start of your child’s sport.

FORMS CHECKLIST:

- Physical Form
- OHSAA Authorization Form
- Logan Elm Emergency Medical Form
- Confirmation of Insurance Coverage Form
- Code of Conduct Informed Consent Agreement
- Concussion Information Sheet
- Sudden Cardiac Arrest Signature Form

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eric.karshner@loganelm.org

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nathaniel.dropsey@loganelm.org
Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION  2018-2019

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

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

Date of Exam

Name ____________________________ Age _______ Grade _______ Date of birth _______ School ____________________________ Sport(s) ______________________

Address ____________________________

Emergency Contact: __________________________________________ Relationship __________________________

Phone (H) ___________(W) ___________ (Cell) ___________ (Email) ___________.

Medicines and Allergies: Please list the prescription and over-the-counter medications 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. Has a doctor ever denied or restricted your participation in sports for any reason? ☐ Yes ☐ No

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? ☐ Yes ☐ No

4. Have you ever had surgery? ☐ Yes ☐ No

HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out during or after exercise? ☐ Yes ☐ No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? ☐ Yes ☐ No

7. Does your heart race or skip beats (irregular beats) during exercise? ☐ Yes ☐ No

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) ☐ Yes ☐ No

10. Do you get lightheaded or feel more short of breath than expected during exercise? ☐ Yes ☐ No

11. Have you ever had an unexplained seizure? ☐ Yes ☐ No

12. Do you get more tired or short of breath more quickly than your friends during exercise? ☐ Yes ☐ No

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

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)? ☐ Yes ☐ No

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? ☐ Yes ☐ No

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? ☐ Yes ☐ No

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? ☐ Yes ☐ No

BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game? ☐ Yes ☐ No

18. Have you ever had any broken or fractured bones or dislocated joints? ☐ Yes ☐ No

19. Have you ever had an injury that required X-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? ☐ Yes ☐ No

20. Have you ever had a stress fracture? ☐ Yes ☐ No

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) ☐ Yes ☐ No

BONE AND JOINT QUESTIONS - CONTINUED

22. Do you regularly use a brace, orthotics, or other assistive device? ☐ Yes ☐ No

23. Do you have a bone, muscle, or joint injury that bothers you? ☐ Yes ☐ No

24. Do any of your joints become painful, swollen, feel warm, or look red? ☐ Yes ☐ No

25. Do you have any history of juvenile arthritis or connective tissue disease? ☐ Yes ☐ No

MEDICAL QUESTIONS

26. Do you cough, wheeze, or have difficulty breathing during or after exercise? ☐ Yes ☐ No

27. Have you ever used an inhaler or taken asthma medicine? ☐ Yes ☐ No

28. Is there anyone in your family who has asthma? ☐ Yes ☐ No

29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? ☐ Yes ☐ No

30. Do you have groin pain or a painful bulge or hernia in the groin area? ☐ Yes ☐ No

31. Have you had infectious mononucleosis (mono) within the past month? ☐ Yes ☐ No

32. Do you have any rashes, pressure sores, or other skin problems? ☐ Yes ☐ No

33. Have you had a herpes (cold sores) or MRSA (staph) skin infection? ☐ Yes ☐ No

34. Have you ever had a head injury or concussion? ☐ Yes ☐ No

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems? ☐ Yes ☐ No

36. Do you have a history of seizure disorder or epilepsy? ☐ Yes ☐ No

37. Do you have headaches with exercise? ☐ Yes ☐ No

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ☐ Yes ☐ No

39. Have you ever been unable to move your arms or legs after being hit or falling? ☐ Yes ☐ No

40. Have you ever become ill while exercising in the heat? ☐ Yes ☐ No

41. Do you get frequent muscle cramps when exercising? ☐ Yes ☐ No

42. Do you or someone in your family have sickle cell trait or disease? ☐ Yes ☐ No

FEMALES ONLY

50. Have you ever had an eating disorder? ☐ Yes ☐ No

51. Do you have any concerns that you would like to discuss with a doctor? ☐ Yes ☐ No

52. Have you ever had a menstrual period? ☐ Yes ☐ No

53. How old were you when you had your first menstrual period? ☐ Yes ☐ No

54. How many periods have you had in the last 12 months? ☐ Yes ☐ No

FEASIBLE ONLY

55. Has a doctor ever told you that you have any heart problems? If so, check all that apply: Asthma Anemia Diabetes Infections Other: __________________________

56. Have you ever used an inhaler or taken asthma medicine? ☐ Yes ☐ No

57. Do you have a history of seizure disorder or epilepsy? ☐ Yes ☐ No

58. Do you have headaches with exercise? ☐ Yes ☐ No

59. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ☐ Yes ☐ No

60. Have you ever been unable to move your arms or legs after being hit or falling? ☐ Yes ☐ No

61. Have you ever become ill while exercising in the heat? ☐ Yes ☐ No

62. Do you get frequent muscle cramps when exercising? ☐ Yes ☐ No

63. Do you or someone in your family have sickle cell trait or disease? ☐ Yes ☐ No

64. Have you ever had an eating disorder? ☐ Yes ☐ No

65. Do you have any concerns that you would like to discuss with a doctor? ☐ Yes ☐ No

66. Have you ever had a menstrual period? ☐ Yes ☐ No

67. How old were you when you had your first menstrual period? ☐ Yes ☐ No

68. How many periods have you had in the last 12 months? ☐ Yes ☐ No

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: __________________________

**Preparticipation Physical Evaluation 2018-2019**

**The Athlete with Special Needs - Supplemental History Form**

**Please complete only if your student has special needs or a disability.**

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Name</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Date of birth</th>
<th>Sport(s)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1. Type of disability</th>
<th>2. Date of disability</th>
<th>3. Classification (if available)</th>
<th>4. Cause of disability (birth, disease, accident/trauma, other)</th>
<th>5. List the sports you are interested in playing</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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

**Explain "yes" answers here**

<table>
<thead>
<tr>
<th>Please indicate if you have ever had any of the following.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Explain "yes" answers here**

| 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 | | |

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: ____________________________

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**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**

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>DATE OF EXAMINATION ______________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Height</strong></td>
<td><strong>Weight</strong></td>
</tr>
<tr>
<td>BP</td>
<td>( / )</td>
</tr>
<tr>
<td>Pulse</td>
<td>Vision R 20/ L20/ Corrected □ Y □ N</td>
</tr>
</tbody>
</table>

**MEDICAL**

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/ears/nose/throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pupils equal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Murmurs (auscultation standing, supine, +/- Valsalva)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location of the point of maximal impulse (PMI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simultaneous femoral and radial pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary (males only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSV, lesions suggestive of MRSA, tinea corporis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MUSCULOSKELETAL**

<table>
<thead>
<tr>
<th>MUSCULOSKELETAL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
</tr>
<tr>
<td>Shoulder/arm</td>
<td></td>
</tr>
<tr>
<td>Elbow/forearm</td>
<td></td>
</tr>
<tr>
<td>Wrist/hand/fingers</td>
<td></td>
</tr>
<tr>
<td>Hip/thigh</td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
</tr>
<tr>
<td>Leg/ankle</td>
<td></td>
</tr>
<tr>
<td>Foot/toes</td>
<td></td>
</tr>
<tr>
<td>Functional</td>
<td></td>
</tr>
<tr>
<td>Duck walk, single leg hop</td>
<td></td>
</tr>
</tbody>
</table>

*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 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 _________________________________________________________

____________________________________________________________

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OHSAA AUTHORIZATION FORM 2018-2019

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
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 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)/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

<table>
<thead>
<tr>
<th>Student’s Signature</th>
<th>Birth date</th>
<th>Grade in School</th>
<th>Date</th>
</tr>
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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 healthcare 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.

http://www.healthy.ohio.gov/vipp/child/returntoplay/concussion
Returning to Daily Activities

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 Learn (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.
5. For more information, please refer to Return to Learn on the ODH website.

Resources
ODH Violence and Injury Prevention Program
http://www.healthy.ohio.gov/vipp/child/returntoplay/

Centers for Disease Control and Prevention
http://www.cdc.gov/headsup/basics/index.htm

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

Brain Injury Association of America
www.biausa.org/

http://www.healthy.ohio.gov/vipp/child/returntoplay/concussion

Returning to Play

1. Returning to play is specific for each person, depending on the sport. Starting 4/26/13, 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. Ohio law prohibits your child from returning to a game or practice on the same day he/she was removed.
4. Be sure that the athletic trainer, coach and physical education teacher are aware of your child’s injury and symptoms.
5. Your athlete should complete a step-by-step exercise -based progression, under the direction of a qualified healthcare professional.
6. 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 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 healthcare provider.

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

____________________________________  ______________
Athlete                                      Date

____________________________________
Athlete  Please Print Name

____________________________________  ______________
Parent/Guardian                              Date
What is Lindsay’s Law? Lindsay’s Law is about Sudden Cardiac Arrest (SCA) in youth athletes. It covers all athletes 19 years or younger who practice for or compete in athletic activities. Activities may be organized by a school or youth sports organization.

Which youth athletic activities are included in Lindsay’s law?
- Athletics at all schools in Ohio (public and non-public)
- Any athletic contest or competition sponsored by or associated with a school
- All interscholastic athletics, including all practices, interschool practices and scrimmages
- All youth sports organizations
- All cheerleading and club sports, including noncompetitive cheerleading

What is SCA? SCA is when the heart stops beating suddenly and unexpectedly. This cuts off blood flow to the brain and other vital organs. People with SCA will die if not treated immediately. SCA can be caused by 1) a structural issue with the heart, OR 2) an heart electrical problem which controls the heartbeat, OR 3) a situation such as a person who is hit in the chest or a gets a heart infection.

What is a warning sign for SCA? If a family member died suddenly before age 50, or a family member has cardiomyopathy, long QT syndrome, Marfan syndrome or other rhythm problems of the heart.

What symptoms are a warning sign of SCA? A young athlete may have these things with exercise:
- Chest pain/discomfort
- Unexplained fainting/near fainting or dizziness
- Unexplained tiredness, shortness of breath or difficulty breathing
- Unusually fast or racing heart beats

What happens if an athlete experiences syncope or fainting before, during or after a practice, scrimmage, or competitive play? The coach MUST remove the youth athlete from activity immediately. The youth athlete MUST be seen and cleared by a health care provider before returning to activity. This written clearance must be shared with a school or sports official.

What happens if an athlete experiences any other warning signs of SCA? The youth athlete should be seen by a health care professional.

Who can evaluate and clear youth athletes? A physician (MD or DO), a certified nurse practitioner, a clinical nurse specialist, certified nurse midwife. For school athletes, a physician’s assistant or licensed athletic trainer may also clear a student. That person may refer the youth to another health care provider for further evaluation.

What is needed for the youth athlete to return to the activity? There must be clearance from the health care provider in writing. This must be given to the coach and school or sports official before return to activity.

All youth athletes and their parents/guardians must review information about Sudden Cardiac Arrest, then sign and return this form.

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LOGAN ELM LOCAL SCHOOLS EMERGENCY MEDICAL FORM

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.

A. RESIDENTIAL PARENT OR GUARDIAN

Mother’s Name ____________________________  Mother’s Daytime Phone No._______________________
Father’s Name _____________________________  Father’s Daytime Phone No. _______________________
Other Name _______________________________  Other Daytime Phone No.     _______________________

B. NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY (Other than Parent)

Name_______________________________________   Relationship____________________________________
Address_________________________________________________ Phone No.   _______________________

PART I OR 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’s Name  __________________________________ Phone No.________________________
Dentist’s Name  __________________________________ Phone No.________________________
Medical Specialist __________________________________ Phone No.________________________
Emergency Room  __________________________________ Phone No.________________________

• 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 YOU COMPLETED PART I

PART II REFUSAL FOR 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
CONFIRMATION OF INSURANCE COVERAGE

As the parent(s) or guardian of ______________________________ we state that our son/daughter is insured against injury in sports by:

1. _____ Our personal policy with the ____________________________ insurance company. We hereby decline to accept school insurance coverage in favor or our coverage with the above stated company. We will be responsible for handling all claims against our policy (including ambulance service) in the event of injury.

2. _____ Have purchased school insurance.

Furthermore, we state that we will not hold any employees of the Logan Elm School District liable in any way as a result of injuries that may be sustained by our son/daughter as a result of athletic participation as a member of Logan Elm High School teams.

____________________________________  ____________________________
Signature of Parent or Guardian Date

CONSENT TO PERFORM URINALYSIS FOR DRUG TESTING

We hereby consent to allow the student named on the front of this form to undergo urinalysis testing for the presence of illicit drugs or banned substances in accordance with the policy and procedure for drug testing of students in interscholastic athletics as approval by the Logan Elm Local School Board.

We understand the collection process will be overseen by a qualified vendor.

We understand that urine samples will be sent only to a certified medical laboratory for actual testing and the samples will be coded to provide confidentiality.

We hereby give our consent to the medical vendor selected by the Logan Elm Local School Board, their laboratory, doctors, employees, or agents, together with any clinic, hospital or laboratory designated by the selected medical vendor to perform urinalysis testing for the detection of illicit drugs or banned substances.

We further give permission to the medical vendor selected by the Logan Elm Local Board, its doctors, employees, or agents to release all results of these tests to the Medical Review Officer (MRO) working for the medical vendor. We understand these results will be forwarded to the building principal and will be also made available to us.

We understand that pursuant to this Informed Consent Agreement will be effective for all athletic sports in which this student athlete might participate during the current school year.

We hereby release the Logan Elm School Board of Education and its employees from any legal responsibility or liability for the release of such information and records.

This will be deemed a consent pursuant to the Family Educational Rights and Privacy of 1974, 20 U>S>C 1232g as amended, and Ohio Revised Code 3319.321, for the release of the test results as authorized by this Informed Consent Agreement or as required by law.

READ ATHLETIC CODE OF CONDUCTED AND EXPECTATIONS AND SIGN!
LOGAN ELM SCHOOLS
ATHLETIC CODE OF CONDUCT
INFORMED CONSENT AGREEMENT

Student Name (Please Print)______________________________________  Grade___________________

AS A STUDENT:

• I understand and agree the participation in athletic activities is a privilege that may be withdrawn for violations of the Athletic Code of Conduct.
• I have read the Athletic Code of Conduct and thoroughly understand the consequences that I will face if I do not honor my commitment to the Athletic Code of Conduct.
• I understand and realize that there is risk of injury in participating in athletic activities.
• I understand that when I participate in my athletic program, I will be subjected to random drug testing and if I refuse, I will not be allowed to practice in any athletic activities. I have read the consent on the reverse of this form and agree to its terms.
• I understand this is binding while a student at Logan Elm.

________________________________________________________________________
Student Signature  Date

AS A PARENT/GUARDIAN/CUSTODIAN:

• I have read the Athletic Code of Conduct and understand the responsibilities of my son/daughter/ward as a participant in athletic activities in the Logan Elm Local Schools.
• I pledge to promote healthy lifestyles for all students of the Logan Elm Schools.
• I understand and realize that there is an assumed risk of injury involved for my son/daughter/ward as a participant in athletic activities.
• I understand that my son/daughter/ward, when participating in any athletic program, will be subjected to random urine drug testing, and if they refuse, will not be allowed to practice or participate in any athletic activities. I have read the consent on the reverse of this form and agree to its terms.
• I understand this is binding while my son/daughter/ward is a student at Logan Elm.

________________________________________________________________________
Parent/Guardian/Custodian Signature  Date

Parent/Guardian/Custodian Name (Print)  Home Phone  Work Phone

Parent/Guardian/Custodian  Address  City  State  Zip