Dublin City School District

Program
2340C F3
Revised 3/6/2020

Responsibility Contract for Overnight Trips

- Student is to read and complete this form.
- Parent/custodian/guardian is to read and complete this form.
- The completed form is to be notarized and returned to the staff member in charge of the trip (Trip Leader), submitted to the building principal, and left in the file in the building office. Copies are to be given to the Trip Leader and Parent/Guardian.

It is a privilege for you to participate in the District-sponsored trip to _____. Because this trip is part of the District's educational program, it is imperative that you adhere to the Code of Conduct for overnight trips as well as the applicable provisions of the general Code of Conduct/Student Discipline Code. You must remember that from the time of departure to your arrival home, you are the responsibility of the District.

I agree:

1. to refrain at all times from the consumption of alcoholic beverages and/or drugs, except parent or prescriber approved medications.
2. to sleep in my assigned room and not entertain other individuals in my room, unless my room door is fully opened and an adult chaperone is notified and/or present.
3. to keep my assigned chaperone advised of my whereabouts at all times.
4. to attend all mandatory activities and meal functions.
5. to adhere to all established curfews.
6. to conduct myself in such a manner as to bring pride to my family, my school, my community, and myself.
7. to adhere to any established dress code.
8. to comply, throughout the trip, with any and all instructions directed to me and/or the group by a chaperone or staff member.

If a problem arises that is serious enough in nature to warrant the below-named student's removal from the travel group, we (the student and parent/guardian) agree to bear any additional costs to return the student home. NOTE: the accompanying professional staff member will make this removal decision after a student has been provided the opportunity to respond to any allegations. The student may also be subjected to discipline upon his/her return home in accordance with general District policies.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The State of Ohio, County of _____.

The foregoing instrument was acknowledged before me this _____ day of _____

by _____.

_____
Notary Public

My commission expires: _____

Original: Building Copies: Trip Leader, Parent/Guardian

Dublin City School District

District-Sponsored Overnight Trip Medical Authorization Form

- Upon central office approval of a district-sponsored overnight trip, the teacher in charge should distribute this form to all participating students.
- Parent/guardian is to read and complete this form, **have it notarized**, and return it to the teacher in charge of the trip. **Incomplete or non-returned forms shall result in the student being excluded from participation.**
- The teacher in charge of the trip shall take all completed forms on the trip for medical emergencies.
- All requests for chaperones to administer any medication requires an Ohio health care prescriber's signature.

Student's name: _____ Sex: _____ Birthdate: _____

Home address: _____ City: _____ Zip: _____

Mother/guardian's name: _____

Phone (H): _____ (W): _____ (Cell or Pager): _____

Father/guardian's name: _____

Phone (H): _____ (W): _____ (Cell or Pager): _____

EMERGENCY NUMBERS (if parent/guardian cannot be reached):

1. Name: _____ Phone (H): _____

Relationship to student: _____ Phone (W): _____

2. Name: _____ Phone (H): _____

Relationship to student: _____ Phone (W): _____

Student's health care provider: _____ Phone: _____

Medical insurance company: _____ Group No.: _____

Insurance company address: _____

Name of policy holder: _____ Identification/Policy No.: _____

If you have insurance, please attach a copy of the front and back of your insurance card to this form.

GENERAL HEALTH CARE INFORMATION

Please provide a copy of most current immunization record.

If your child was recently hospitalized, has a fracture or needs specific medical care, please attach written health care provider instructions to this form.

Please check all that apply to your child.

☐ Animal Allergies	☐ Poison Ivy allergy	☐ Activity restrictions	☐ Heart problem
☐ Bee/Insect Allergies	☐ Bleeding problem	☐ Dietary restrictions	☐ Migraines
☐ Drug Allergies	☐ Mobility concerns	☐ Asthma	☐ Glasses/contacts
☐ Environmental Allergies	☐ Sleep walking	☐ Seizures	☐ Ear infections/aids
☐ Food Allergies	☐ Bed wetting	☐ Diabetes	☐ Other _____

Please describe any medical condition including severity and treatment. _____

_____

Food Restrictions/Allergies: _____

District-Sponsored Overnight Trip
Medical Authorization Form

Student's name: _____

MEDICATION

- Students in middle and high school may self-carry their nonprescription and/or emergency medication.
- Parent/guardian is responsible for supplying all medication in its original container, labeled with student's name, and should only include the total number of doses needed for the duration of the trip.
- All medication to be administered by a chaperone will require signed approval by a healthcare prescriber.
- For medication administration procedure, see Board Policy 5330, "Use of Medications".
- Please follow the direction of the trip coordinator for medication drop off procedure.
- Section "A" (Chaperone Administered Medication & Emergency Medication) is to be completed and signed by an Ohio licensed healthcare prescriber.
- Section "B" (Self-Carry Medication [Nonprescription Medication]) is to be completed by the parent/guardian.
- Section "C" is the Parent/Guardian Authorization, Emergency Consent, and Signature.

SECTION A – CHAPERONE ADMINISTERED MEDICATION & EMERGENCY MEDICATION (prescriber to complete)

Medication	Dose/Route	Time(s) to be given	Side Effects

Please list any special storage or considerations: _____

If medication is an inhaler, EpiPen, or medication and supplies for diabetic management, may the student self-carry? Yes ☐ No ☐

As a licensed health care prescriber in the state of Ohio, and at the request of this student's parent/guardian, I direct that the above medication(s) be administered as indicated above.

Prescriber's printed name and title: _____

Prescriber's signature: _____ Phone: _____ Date: _____

SECTION B – SELF-CARRY MEDICATION (Nonprescription Medication) (parent/guardian to complete)

Medication	Dose/Route	Time(s) to be given	Side Effects

SECTION C – PARENT/GUARDIAN AUTHORIZATION, EMERGENCY CONSENT, AND SIGNATURE

PARENT AUTHORIZATION AND EMERGENCY CONSENT

The information on this form is correct and complete to the best of my knowledge, and my child has my permission to participate in this event, with restrictions as noted. I understand and consent to the sharing of this information with all appropriate personnel who will be supervising my child for the duration of this trip or who may be responsible for the welfare of my child.

In the event I or another legal guardian cannot be reached in a medical or dental emergency, I consent for a school staff member to accompany my child to a medical facility. I authorize emergency medical or dental treatment by a licensed physician or dentist.

This authorization does not cover major surgeries or treatments unless the medical opinions of two other licensed physicians or dentists concur in the necessity and urgency for such surgery/treatments BEFORE they are performed.

NOTARY WITNESS TO PARENT/GUARDIAN SIGNATURE

Parent/guardian signature _____ Date _____

State of Ohio, County of _____

The foregoing instrument was acknowledged before me this _____ day of _____

by _____.

_____

Notary Public
My commission expires _____

Dublin City School District

Allergy and Anaphylaxis Emergency Orders and Action Plan

Student's name: _____ Birthdate: _____ Phone: _____

Student's address: _____
street city state zip

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

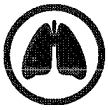
Extremely reactive to the following: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING: **SEVERE** SYMPTOMS



LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - Antihistamine
  - Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Adverse reaction to be reported to prescriber: _____

_____

Adverse reactions that may occur to another child for whom the epinephrine is not prescribed, should such a child receive a dose of the medication:

_____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

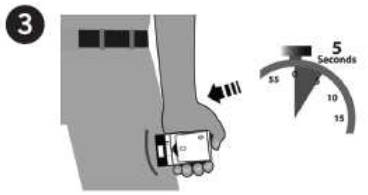
Start Date: _____ End Date: _____

Parent/Guardian authorization signature Date Physician/HCP authorization signature Date

Allergy and Anaphylaxis Emergency Orders and Action Plan (cont.)

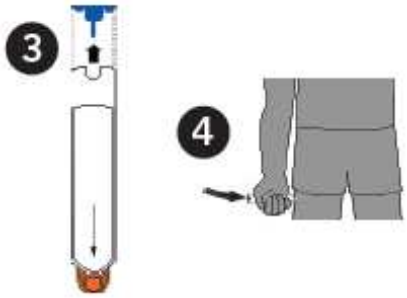
Student's name: _____

AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO



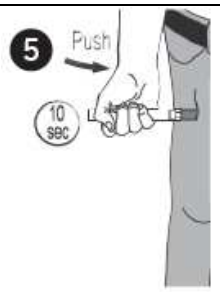
1. Remove Auvi-Q® from the outer case.
2. Pull off the red safety guard.
3. Place black end of Auvi-Q® against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.

EPIPEN®, EPIPEN JR®, AUTHORIZED GENERIC OF EPIPEN®, or USP AUTO-INJECTOR, MYLAN DIRECTIONS



1. Remove the EpiPen®, EpiPen Jr®, authorized generic of EpiPen®, USP auto-injector, Mylan from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES DIRECTIONS



1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION

SELF-CARRY AUTHORIZATION

[ ] Physician acknowledgement of training in the proper use of auto-injector
[ ] Self-carry (student is capable of possession and proper use of auto-injector)

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS – CALL 911

Rescue Squad: _____
Doctor: _____ Phone: _____
Parent/Guardian: _____ Phone: _____

OTHER EMERGENCY CONTACTS

Name/Relationship: _____
Phone: _____
Name/Relationship: _____
Phone: _____

Physician signature Date

Parent/Guardian authorization signature Date

Dublin City School District

Asthma Action Plan and Orders

Student's name: _____ Birthdate: _____ Phone: _____

Student's address: _____ School/Grade: _____
street city state zip

I. Healthcare Provider's Section

Severity classification ☐ Intermittent ☐ Mild persistent ☐ Moderate persistent ☐ Severe persistent
Asthma triggers ☐ none ☐ animals ☐ cold air ☐ exercise ☐ pollen ☐ respiratory illness
☐ smoke, chemicals, strong odors ☐ other (food, emotions, insects, etc.) _____
Peak flow meter personal best _____

Quick relief medication orders: (check the appropriate quick relief med(s)) ☐ Uses inhaler with spacer
☐ Albuterol (strength _____): ____ puffs (Proair®, Ventolin HFA®, Proventil®) as needed every ____ hours for cough/wheeze
☐ Levalbuterol (strength _____): ____ puffs (Xopenex®) as needed every ____ hours for cough/wheeze
☐ Other _____ Epi auto-injector ☐ 0.3 mg ☐ Jr.0.15 mg

SIDE EFFECTS of medication(s): _____

Green Zone: Doing Well
Symptoms: Breathing is good – No cough or wheeze
Peak flow meter _____ (more than 80% of personal best)
Physical activity: ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity
☐ with all activity ☐ when the child fees he/she needs it

Yellow Zone: Caution – DO NOT LEAVE STUDENT UNATTENDED
Symptoms: Problems breathing – Cough, wheeze, or chest tight
Peak flow meter _____ to _____ (between 50% and 79% of personal best)

- If student is using quick relief inhaler > 2 times a week or requires frequent observation by school staff → **Notify** parents + school nurse.
- If student is coughing, wheezing and having difficulty breathing:
  ☐ Give ____ puffs of quick relief inhaler. May repeat in ____ minutes. → **Notify** parents and school nurse if repeated.
- If **NO** improvement after repeated dose, call 911 – see below.

Red Zone: CALL 911 and DO NOT LEAVE STUDENT UNATTENDED
Symptoms: Difficulty talking – Shortness of breath – Getting worse instead of better –
Blue appearance (lips/nails) – Medicine is not helping
Peak flow meter _____ (less than 50% of personal best)
☐ Give ____ puffs quick relief inhaler or nebulizer treatment and **notify** parents and school nurse.
☐ This student needs Epi auto-injector for severe asthma attacks and
☐ can carry and self-administer Epi auto-injector ☐ needs help giving the Epi auto-injector ☐ other _____

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Special storage instructions: _____

Start date: _____ End date: _____

Healthcare provider

Name _____ Date _____ Phone _____ Signature _____

Student's name: _____ Birthdate: _____

II. Parent/Guardian's Section

I hereby request and give my permission for school district personnel to administer this prescribed medication to my child in accordance with the specific written orders from our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of this medication to the school clinic and will notify the school immediately if we change our medical provider or the need for this medication is discontinued.

I understand this medication can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff are authorized to perform this task.

If this medication is required for extracurricular activities, I agree to provide a separate dose to school staff supervising my child's extracurricular activities

A new Asthma Action Plan and Orders form must be submitted each school year.

I understand that if any changes are needed on this Asthma Action Plan and Orders form, it is the parent's responsibility to contact the school nurse and submit a new form.

I understand that my child may be eligible for Section 504 plan.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers as necessary for medical management.

Parent/Guardian signature Date

Home address Daytime phone

PREPARTICIPATION PHYSICAL EVALUATION – Ohio High School Athletic Association – 2020-2021

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name:_____ Date of birth: _____ Grade in School: _____

Date of examination: _____ Sport(s):_____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

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 (i.e., medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
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.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**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)?		
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)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

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, had tingling, had 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 had, 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 foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

Additional Questions as authorized by the Ohio High School Athletic Association – These questions were not a part of the revised 5th edition PPE as authored by the American Academy of Pediatrics.

1. On average, how many days per week do you engage in moderate to strenuous exercise (makes you breathe heavily or sweat)? _____
2. On average, how many minutes per week do you engage in exercise at this level? _____

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: _____

PREPARTICIPATION PHYSICAL EVALUATION – Ohio High School Athletic Association – 2020-2021

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: _____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 use 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 as having 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 whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (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 questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

PREPARTICIPATION PHYSICAL EVALUATION – Ohio High School Athletic Association – 2020-2021

PHYSICAL EXAMINATION FORM

Name: _____ Date of Birth: _____ Grade in School: _____

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, e-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-enhancing 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, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: □ Y □ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, DC, NP, or PA

PREPARTICIPATION PHYSICAL EVALUATION – OHIO HIGH SCHOOL ATHLETIC ASSOCIATION – 2020-21

MEDICAL ELIGIBILITY FORM

Name: _____ Date of Birth: _____ Grade in School: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date of Exam: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, DC, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

PREPARTICIPATION PHYSICAL EVALUATION 2020-2021

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 2020-2021

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 2020-2021

2020-2021 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/OtherEligibiltyDocs/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), enrollment documents, financial and scholarship records, 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, 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 another health care provider 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.

I **have read and signed** the Ohio Department of Health's **Sudden Cardia Arrest 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 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.

Ohio Department of Health

OHIO INJURY PREVENTION PARTNERSHIP
Injury Prevention Policy and Advocacy Action Group

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

Rev. 09.16

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.html

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. *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*

_____ _____

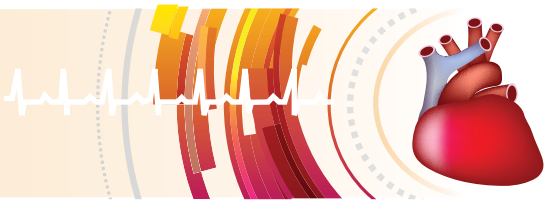
Parent/Guardian Date

Ohio Department of Health

Rev. 9.16

Sudden Cardiac Arrest and Lindsay's Law

Parent/Athlete Signature Form



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.

_____	_____
Parent/Guardian Signature	Student Signature
_____	_____
Parent/Guardian Name (Print)	Student Name (Print)
_____	_____
Date	Date