

# OSSAA PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM

\_\_\_\_\_  
**NAME OF STUDENT**

\_\_\_\_\_  
**SEX**

\_\_\_\_\_  
**PARENT OR GUARDIAN**

\_\_\_\_\_  
**HOME ADDRESS**

\_\_\_\_\_  
**GRADE/AGE HM PHONE**

\_\_\_\_\_  
**WK PHONE**

**PARENT or GUARDIAN  
 STUDENT HEALTH HISTORY**

**PHYSICIAN**

Parent or Guardian Please answer "Yes" or "No  
 Only to the Following Questions

Vitals	Satis- Factory	Exam Comments	Follow Up
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YES/NO

YES/NO

**Chronic and/or Recurrent Illness** \_\_\_\_\_ **HT.** \_\_\_\_\_

**Hospitalization?** \_\_\_\_\_ **WT.** \_\_\_\_\_

**Operations?** \_\_\_\_\_ **BP.** \_\_\_\_\_

**Taking Medication?** \_\_\_\_\_ **Pulse** \_\_\_\_\_

**Organs Missing?** \_\_\_\_\_ **GENERAL** \_\_\_\_\_

**Heat Exhaustion?** \_\_\_\_\_ **Head** \_\_\_\_\_

**Dizziness, Fainting, Seizures?** \_\_\_\_\_ **Eyes** \_\_\_\_\_

**Knocked Out?** \_\_\_\_\_ **Ears** \_\_\_\_\_

**Concussion?** \_\_\_\_\_ **Dental** \_\_\_\_\_

**Wear Glasses/Contacts?** \_\_\_\_\_ **Chest** \_\_\_\_\_

**Hearing Problems?** \_\_\_\_\_ **Heart** \_\_\_\_\_

**Allergic to Medications?** \_\_\_\_\_ **Abdomen** \_\_\_\_\_

**High-Blood Pressure?** \_\_\_\_\_ **Genitalia** \_\_\_\_\_

**Hernia?** \_\_\_\_\_ **Skin** \_\_\_\_\_

**Bone, Joint, Spine Injury?** \_\_\_\_\_ **Extrem., Back, Neck** \_\_\_\_\_

**SUMMARY OF COMMENTS:**

**Liver, Spleen, Kidney or Skin Problem**

Explain any yes answers or any other pertinent information concerning health history:

Check if additional comments are on the reverse side. \_\_\_\_\_

**SPORTS PARTICIPATION APPROVED**

YES \_\_\_\_\_ NO \_\_\_\_\_ DEFERRED \_\_\_\_\_

**LIMITATIONS or FOLLOW-UP:**

The above information is correct to the best of my knowledge. I hereby give my informed consent for the above mentioned to participate in activities. I understand the risk of injury in athletic participation. If any son/daughter becomes ill or is injured, necessary medical care can be instituted by physicians, coaches trainers or other personnel properly trained.

**X** \_\_\_\_\_  
**Signature of Parent or Guardian / Date**

**X** \_\_\_\_\_  
**Signature of Physician / Date**