

Lakewood Athletics

Participation Forms

Annual Forms Packet

You must fill out these forms every school year.

Emergency Medical Form

OHSAA Physical Form

Sudden Cardiac Arrest Form

Please return all forms to the Athletic Office at LHS or your middle school main office. Do not return the forms to your coach! You must have these forms on file to participate in practice, scrimmages and athletic contests.

RETURN THIS FORM TO YOUR COACH **NOT** THE ATHLETIC OFFICE



PARENT NOTIFICATION EMERGENCY MEDICAL & STUDENT RELEASE AUTHORIZATION

MAIN CONTACTS: In case of an emergency with your student, the school office will call and notify you at the primary phone number provided. If you are not reached at the primary number, phone calls will be made to the contacts and phone numbers listed below in the order given until someone is notified. The same procedure will be used each day after 9 a.m. if your elementary student or Harding Middle School student is absent and the school has not been notified. Automated attendance calls are used at Garfield Middle School and LHS.

Child's Name _____ Grade _____ Primary Phone: _____

Place an X in one or both columns at the far right for the contacts for whom you allow to authorize emergency medical treatment for your student and whom your student may be released.

Print Full Name	Home Phone	Cell Phone	Work Phone	Emergency Medical	Student Release
1 st Contact/Relationship	()	()	()		
2 nd Contact/Relationship	()	()	()		
3 rd Contact/Relationship	()	()	()		
4 th Contact/Relationship	()	()	()		

PART 1 – TO GRANT CONSENT

In the event reasonable attempts to contact me at the above numbers have been unsuccessful, I hereby give my consent for:
(1) the administration of any treatment deemed necessary by:

(Physician) Dr. _____, Address _____ Phone () _____

(Dentist) Dr. _____, Address _____ Phone () _____

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 preferred hospital: Lakewood Fairview

If the emergency is such that your child needs immediate attention, he/she will be taken to the most accessible of these hospitals. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of the surgery, are obtained before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, food supplements, modified diets, fluoride supplements, and any physical impairment to which a physician should be alerted: _____

Date: _____ Parent Signature: _____

PART 2 – REFUSAL TO CONSENT

In the event reasonable attempts to contact me at the above numbers have been unsuccessful, 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 no action, or to:

Date: _____ Parent Signature: _____

RETURN THIS FORM TO YOUR COACH **NOT** THE ATHLETIC OFFICE

Student Last Name

Student First Name

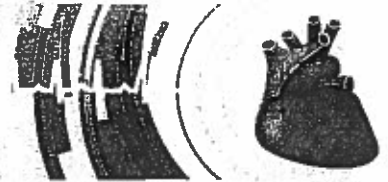
Sudden Cardiac Arrest and Lindsay's Law Information for the Youth Athlete and Parent/Guardian



- Lindsay's Law is about Sudden Cardiac Arrest (SCA) in youth athletes. This law went into effect in 2017. SCA is the leading cause of death in student athletes 19 years of age or younger. SCA occurs when the heart suddenly and unexpectedly stops beating. This cuts off blood flow to the brain and other vital organs. SCA is fatal if not treated immediately
- "Youth" covered under Lindsay's Law are all athletes 19 years of age or younger that wish to practice for or compete in athletic activities organized by a school or youth sports organization.
- Lindsay's Law applies to all public and private schools and all youth sports organizations for athletes aged 19 years or younger whether or not they pay a fee to participate or are sponsored by a business or nonprofit. This includes:
 - 1) All athletic activities including interscholastic athletics, any athletic contest or competition sponsored by or associated with a school
 - 2) All cheerleading, club sports and school affiliated organizations including noncompetitive cheerleading
 - 3) All practices, interschool practices and scrimmages
- Any of these things may cause SCA:
 - 1) Structural heart disease. This may or may not be present from birth
 - 2) Electrical heart disease. This is a problem with the heart's electrical system that controls the heartbeat
 - 3) Situational causes. These may be people with completely normal hearts who are either are hit in the chest or develop a heart infection
- Warning signs in your family that you or your youth athlete may be at high risk of SCA.
 - o A blood relative who suddenly and unexpectedly dies before age 50
 - o Any of the following conditions: cardiomyopathy, long QT syndrome, Marfan syndrome, or other rhythm problems of the heart
- Warning signs of SCA. If any of these things happen with exercise, see your health care professional.
 - Chest pain/discomfort
 - Unexplained fainting/near fainting or dizziness
 - Unexplained tiredness, shortness of breath or difficulty breathing
 - Unusually fast or racing heart beats
- The youth athlete who faints or passes out before, during, or after an athletic activity **MUST** be removed from the activity. Before returning to the activity, the youth athlete must be seen by a health care professional and cleared in writing.
- If the youth athlete's biological parent, sibling or child has had a SCA, then the youth athlete must be removed from activity. Before returning to the activity, the youth athlete must be seen by a health care professional and cleared in writing.
- Any young athlete with any of these warning signs cannot participate in practices, interschool practices, scrimmages or competition until cleared by a health care professional.

- Other reasons to be seen by a healthcare professional would be a heart murmur, high blood pressure, or prior heart evaluation by a physician.
- Lindsay's Law lists the health care professionals who may evaluate and clear youth athletes. They are a physician (MD or DO), a certified nurse practitioner, a clinical nurse specialist or 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 and family to another health care provider for further evaluation. Clearance must be provided in writing to the school or sports official before the athlete can return to the activity.
- Despite everyone's best efforts, sometimes a young athlete will experience SCA. If you have had CPR training, you may know the term "Chain of Survival." The Chain of Survival helps anyone survive SCA.
- Using an Automated External Defibrillator (AED) can save the life of a child with SCA. Depending on where a young athlete is during an activity, there may or may not be an AED close by. Many, but not all, schools have AEDs. The AEDs may be near the athletic facilities, or they may be close to the school office. Look around at a sporting event to see if you see one. If you are involved in community sports, look around to see if there is an AED nearby.
- If you witness a person experiencing a SCA: First, remain calm. Follow the links in the Chain of Survival:
 - ❖ Link 1: Early recognition
 - Assess child for responsiveness. Does the child answer if you call his/her name?
 - If no, then attempt to assess pulse. If no pulse is felt or if you are unsure, call for help "someone dial 911"
 - ❖ Link 2: Early CPR
 - Begin CPR Immediately
 - ❖ Link 3: Early defibrillation (which is the use of an AED)
 - If an AED is available, send someone to get it immediately. Turn it on, attach it to the child and follow the instructions
 - If an AED is not available, continue CPR until EMS arrives
 - ❖ Link 4: Early advanced life support and cardiovascular care
 - Continue CPR until EMS arrives
- Lindsay's Law requires both the youth athlete and parent/guardian to acknowledge receipt of information about Sudden Cardiac Arrest by signing a form.

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) a 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 view the Ohio Department of Health (ODH) video about Sudden Cardiac Arrest, review the ODH SCA handout and then sign and return this form.

Parent/Guardian Signature

Student Signature

Parent/Guardian Name (Print)

Student Name (Print)

Date

Date



PREPARTICIPATION PHYSICAL EVALUATION 2019-2020

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

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

Date of Exam, Name, Date of birth, Sex, Age, Grade, School, Sport(s), Address, Emergency Contact, Relationship, Phone (H), (W), (Cell), (Email)

Medicines and Allergies: Please list the prescription and over-the-counter medicines and supplements (herbal and nutritional-including energy drinks/ protein supplements) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

- Medicines, Pollens, Food, Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

Table with columns: GENERAL HEALTH QUESTIONS ABOUT YOU, HEART HEALTH QUESTIONS ABOUT YOUR FAMILY, BONE AND JOINT QUESTIONS. Rows 1-21.

BONE AND JOINT QUESTIONS - CONTINUED. Rows 22-25.

MEDICAL QUESTIONS. Rows 26-51.

FEMALES ONLY. Rows 52-54.

Explain "yes" answers here

Blank lines for explaining "yes" answers.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student, Signature of parent/guardian, Date

The student has family insurance Yes No If yes, family insurance company name and policy number:



Ohio High School Athletic Association



PREPARTICIPATION PHYSICAL EVALUATION 2019-2020

THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

PLEASE COMPLETE ONLY IF YOUR STUDENT HAS SPECIAL NEEDS OR A DISABILITY.

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device or prosthetic?		
7. Do you use a special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you have any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student _____ Signature of parent/guardian _____ Date: _____



PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		DATE OF EXAMINATION	
Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female
BP	Pulse	Vision R 20/	L20/
		Corrected	<input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL		NORMAL	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat Pupils equal Hearing			
Lymph nodes			
Heart Murmurs (auscultation standing, supine, +/- Valsalva) Location of the point of maximal impulse (PMI)			
Pulses Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional Duck walk, single leg hop			

^aConsider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third part present is recommended.
^cConsider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

CLEARANCE FORM

Note: Authorization forms (pages 5 and 6) must be signed by both the parent/guardian and the student.

Name _____ Sex M F Age _____ Date of birth _____

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not Cleared
 - Pending further evaluation
 - For any sports
 - For certain sports _____
 - Reason _____

Recommendations _____

I have examined the above-named student and completed the pre-participation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. In the event that the examination is conducted en masse at the school, the school administrator shall retain a copy of the PPE. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician or medical examiner (print/type) _____ Date of Exam _____
Address _____ Phone _____

Signature of physician/medical examiner _____, MD, DO, D.C., P.A. or A.N.P.

EMERGENCY INFORMATION

Personal Physician _____ Phone _____

In case of Emergency, contact _____ Phone _____

Allergies _____

Other Information _____

PREPARTICIPATION PHYSICAL EVALUATION 2019-2020
2019-2020 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/OtherEligibilityDocs/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), residence address of the student, academic work completed, grades received and attendance data.

I consent to the OHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

I understand that if I drop a class, take course work through College Credit Plus, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility. I accept full responsibility for compliance with Bylaw 4-4-1, Scholarship, and the passing five credit standard expressed therein.

I understand all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required in order for the student to return to participation.

I have read and signed the Ohio Department of Health's Concussion Information Sheet and have retained a copy for myself.

By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.

***Must Be Signed Before Physical Examination**

Student's Signature _____ Birth date _____ Grade in School _____ Date _____

Parent's or Guardian's Signature _____ Date _____

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 2019-2020

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