



**2021-2022**

## **MCS SCHOOL ATHLETIC PACKET**

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- All athletes are required to have a physical prior to the first practice of any sport of any season
- Physicals are good for one calendar year
- All athletic fees/expenses will be billed to your FACTS account-  
Fees = JH- \$75 HS-\$115 Family Max \$285
- Please fill out and return completed packet to the High School Office
- Academic eligibility will be determined through interim reports and quarterly report cards
- Athletes and their parents are required to review the Athletic Handbook

**Sports Packet Due:**

**Fall- August 1<sup>st</sup>**

**Winter- October 22<sup>nd</sup>**

**Spring- February 21<sup>st</sup>**



## PREPARTICIPATION PHYSICAL EVALUATION | Ohio High School Athletic Association – 2021-2022

### 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  $\geq 3$  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 polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		





**Additional questions, as authorized by the Ohio High School Athletic Association, were not a part of the revised 5<sup>th</sup> edition PPE as authored by the American Academy of Pediatrics and are optional.**

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: \_\_\_\_\_

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**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:

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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:

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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 – 2021-2022

## PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade in School: \_\_\_\_\_

### 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, 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>		
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 <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>		

<sup>a</sup> 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 – 2021-2022

### 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 | 2021-2022

**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 | 2021-2022

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**





## PREPARTICIPATION PHYSICAL EVALUATION | 2021-2022

### 2021-2022 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 guardian*


 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](https://www.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 Cardiac 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.



<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.html>

National Federation of State High School Associations  
[www.nfhs.org](http://www.nfhs.org)

Brain Injury Association of America  
[www.biausa.org/](http://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







### CONSENT TO TREATMENT

ATHLETE NAME: _____		
_____ Last	_____ First	_____ Middle
SCHOOL: _____ SPORT(S): _____		
PHONE NUMBER: _____ DATE OF BIRTH: _____		

I am aware that the athletic training services and care for \_\_\_\_\_ High School ("School") sanctioned athletic activities will be provided by the Avita Health System's Center for Sports Health, its hospitals (Galion Community Hospital and Bucyrus Community Hospitals (the "Hospitals")), subsidiaries and affiliates (collectively, "Avita"). By providing my signature below, I consent to medical care and treatment provided by Avita and its contracted or employed athletic trainer(s) and other medical personnel ("Personnel"). I understand that this care may include triage, evaluation, examination, special tests, and limited medical treatment of injuries sustained during participation in athletic activities sponsored by the School and/or at Ohio High School Athletic Association ("OHSAA") athletic events ("Athletic Trainer Services"). I understand that as a result of the medical evaluation, the Athlete may be transported to a hospital emergency department for further treatment if deemed advisable by Avita Personnel, medical responders, School or OHSAA officials.

I am also aware that if the Athlete sustains an injury and is participating in School sanctioned athletic activities, it is imperative that Avita Personnel be able to communicate freely with individuals involved. **I hereby consent to Avita Personnel communicating with the Athlete and any and all School officials, coaches, staff, administrators, OHSAA representatives, medical personnel and physicians involved in the Athlete's injury and/or treatment.**

**If this box is checked, it applies to your school**

☐ Your school has purchased a Neuropsychological Concussion Program. This program assists our Personnel in evaluating and treating traumatic brain injuries (e.g., concussion). A computerized exam is usually given to athletes before beginning contact sport practice or competition. Athletes are tested at least once during their four (4) years of participation in high school interscholastic athletics. Athletes participating in sports where a head injury is more likely to happen (eg. soccer, basketball, wrestling, football, baseball) will be tested. Athletes participating in tennis, cross country, golf, swimming, or track (except field events), will not be pre-tested. If an athlete is believed to have suffered a head injury, the test is used to help determine the severity of the head injury, and whether the injury has healed. **I hereby authorize Avita, its affiliated Hospitals, and Personnel to test the Athlete pursuant to the Neuropsychological concussion program.**

**This consent is limited to the provision of Athletic Trainer Services, and does not obligate the Athlete to receive ongoing medical treatment or services from Avita outside of the services rendered in connection with School sanctioned athletic programs.**

\_\_\_\_\_  
Signature of Athlete / Parent or Guardian  
(Parent or Guardian must sign if Athlete is under 18)

\_\_\_\_\_  
Date



## 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

Mansfield Christian Athletics

"Parent Information and Forms Sign-Off"

**2021-2022 School Year**

Name of Student-Athlete: \_\_\_\_\_ Sport: \_\_\_\_\_

(Second) Student Athlete: \_\_\_\_\_ Sport: \_\_\_\_\_

Parent/Guardian (print name): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Download and view each of the items located on the Athletics page of the MCS web site. Once you have read/reviewed each item, print this form, initial each item listed and return this form signed to the athletic office. This must be completed before your son/daughter will be permitted to participate in a regular season game.

Reviewing this information takes the place of the meeting if unable to attend. It is a requirement of the OHSAA and Mansfield Christian School that you review the following information in order for your son/daughter to be eligible to compete in inter-scholastic competition. Please contact the athletic office with any additional questions or email Mr. Mike LaCroix at [lacroix.mike@mcsflames.org](mailto:lacroix.mike@mcsflames.org).

\_\_\_\_\_ Review the OHSAA PowerPoint

\_\_\_\_\_ Read the Athletic Handbook

\_\_\_\_\_ Complete the OHSAA Pre-participation Physical Evaluation Form and OHSAA form

\_\_\_\_\_ Read, sign and return Concussion Information Form

\_\_\_\_\_ Pay Athletic Fee (\$115 High School; \$75 Jr. High; \$285 Family Max)

\_\_\_\_\_ Student athlete has health care coverage

\_\_\_\_\_ Copy of auto insurance card to transport students

I have reviewed/revised each of the above items and acknowledge the information contained within.

\_\_\_\_\_  
(Signature of parent/guardian)

\_\_\_\_\_  
(Date)



# Ohio High School Athletic Association Eligibility Checklist

For High School Students Enrolled and/or Participating at an OHSAA Member School (Updated 5/4/17)

**Before you play, you must be eligible. Please review the following checklist with your parents. Unchecked boxes may mean you are NOT eligible. For questions, see your principal or athletic administrator.**

- ☐ I am officially enrolled in an OHSAA member high school or participating in accordance with state law.
- ☐ I am enrolled in at least five one credit courses or the equivalent, each of which counts toward graduation.
- ☐ I received passing grades in at least five one credit courses or the equivalent, each of which count toward graduation, during the immediately preceding grading period.
- ☐ I have a biological and/or adoptive parent who lives in Ohio.
- ☐ I have not changed schools without a corresponding move by my parents or legal guardian or by qualifying for one of the exceptions to the OHSAA transfer regulation.
- ☐ If I have changed schools (transferred), I have followed up with my new school to ensure that all proper forms (if applicable) have been submitted to the OHSAA Office.
- ☐ I have not been enrolled in high school for more than eight semesters.
- ☐ I understand I will become ineligible once I turn 20 years old.
- ☐ I have not received an award, equipment or prize valued at greater than \$400 per item per source.
- ☐ I am competing under my true name and have provided my school with my correct home address.
- ☐ I have not competed in a **mandatory** open gym/facility, conditioning or instructional program outside the school season.
- ☐ I have not been coached or provided instruction **by a school coach** in a team sport in which I participate other than during my sport season, during an instructional period approved by the OHSAA or for no more than 10 days between June 1 and July 31.
- ☐ I am not competing on a non-school team or in non-school competition as an individual **during my school team's season** in the same sport.
- ☐ I have not been recruited for athletic purposes to attend this school.
- ☐ I am not using anabolic steroids or other performance-enhancing drugs.
- ☐ I have had a physical examination within the past year and it is on file at my school.
- ☐ My parents and I attended a preseason meeting at my school which the OHSAA requires to be held no later than two weeks after the beginning of each sports season. We viewed a presentation prepared by the OHSAA to review key eligibility issues, healthy lifestyles and sporting behavior.
- ☐ My school also reviewed with my parents and me its concussion management protocol, we reviewed and signed the Ohio Department of Health's "Concussion Information Sheet" prior to participation and we reviewed a short presentation on concussions available at no cost at [www.nfhslearn.com](http://www.nfhslearn.com).
- ☐ \*My school also reviewed with my parents and me the Sudden Cardiac Arrest video, and we reviewed and have signed the Ohio Department of Health's "Sudden Cardiac Arrest Information Sheet" prior to participation and we reviewed a short presentation on Sudden Cardiac Arrest.
- ☐ My parents and I have signed the OHSAA Authorization Form and the OHSAA Eligibility and Authorization Statement, and they are on file at my school.

Student Printed Name

Parent/Guardian Printed Name

Student Signature

Parent/Guardian Signature

Student Date

Parent/Guardian Date

**NOTE: This form has been provided as a service to the OHSAA membership for schools to utilize with student-athletes and their parents/guardians. Use of this form is at the sole discretion of each member school.**

\* Indicates that the OHSAA, along with the Ohio Department of Health, Ohio Department of Education, Nationwide Children's Hospital and the Ohio Chapter of the American Cardiology, is in the process of developing the new requirements for coaches, parents and students regarding **Sudden Cardiac Arrest**. These new standards are mandated by law and become effective August 1, 2017. As of May 8, the videos that coaches, students and parents will view and the information sheet for students and parents were not completed. As soon as all materials are finalized and available, the OHSAA will notify the member schools and post the information on our website ([www.ohsaa.org](http://www.ohsaa.org)).



# Student Participant Contract

I \_\_\_\_\_, have chosen to participate in  
(Student's Printed Name)

\_\_\_\_\_ at  
(Sport)

Mansfield Christian School.  
(School Name)

I commit myself to continuously work toward the goal of top physical fitness. To do anything which would harm my body would not be in my best interest or the best interest of my team and school.

I agree to remain free from tobacco, alcohol, steroids and other performance-enhancing or recreational drugs during my sports season and throughout the entire school year. I fully understand this pledge extends to seven days per week.

If I have a problem or I need help fulfilling this contract, I understand the coaches, administrators and/or counselors will be available to help me.

I have read and understand the OHSAA and MCS athletic policies/code of conduct and the consequences for violations of these policies or codes.

I pledge to follow all the rules and policies and to help all my teammates abide by the same athletic rules and policies.

\_\_\_\_\_  
(Student's Signature)

\_\_\_\_\_  
(Date)

As the parent/guardian of \_\_\_\_\_,  
(Student's Printed Name)

I understand and support this contract and pledge that my student has signed. Optimum health and education are the goals of our athletic program, and I support the school in its efforts to attain these goals.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Coach's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Date)

# MANSFIELD CHRISTIAN ATHLETE UNIFORM CONTRACT

✓ I, \_\_\_\_\_  
(Additional student) \_\_\_\_\_ recognize that the uniforms  
belong to the school and I must also respect other people's property. This can be done  
by:

- Wearing the uniform only at games
- Washing the uniform inside out
- Washing it in cool water
- Hanging it to dry
- NOT BLEACHING WHITE UNIFORMS- use non-chlorine bleach  
or color safe product like Oxi-Clean or Borax.

- ✓ I realize that I must carry **both** uniforms to each game.
- ✓ I realize that if a uniform is torn, I will bring it to the attention of my coach, so it can be repaired.  
(Please do not try to repair it without permission of the Athletic Administrator.)
- ✓ I realize that any damage to the uniform while in my possession may result in the replacement of  
the uniform. A replacement fee of \$100.00 will be assessed for each set.
- ✓ I realize that the uniform needs to be returned within a week of the last game. Failure to return  
the uniform within a week will result in a late uniform fee of \$25.00.
- ✓ I also realize I will have to pay \$25.00 for each subsequent month until report cards are issued.
- ✓ I realize that I will not receive my report card until the fee owing is paid AND the uniform is  
returned. At report card time, a replacement fee of \$100.00 will be assessed for each set of  
uniforms not returned in addition to the other fines.

My AWAY uniform number is: \_\_\_\_\_ Color: \_\_\_\_\_  
(Additional Student) \_\_\_\_\_ Color: \_\_\_\_\_  
My HOME uniform number is: \_\_\_\_\_ Color: \_\_\_\_\_  
(Additional Student) \_\_\_\_\_ Color: \_\_\_\_\_  
My WARMUP: \_\_\_\_\_ OTHER EQUIPMENT: \_\_\_\_\_  
\_\_\_\_\_

I, as the athlete, understand, my responsibility to care for the uniform/equipment, bring it to the  
games and return the uniform/equipment promptly or pay the fine and/or replacement fees.

Athlete's signature:

\_\_\_\_\_  
(Additional Student) \_\_\_\_\_

I, as the parent, understand my responsibilities to assist my athlete in being prompt and  
responsible for the care and return of the uniforms/equipment issued.

Parent signature: \_\_\_\_\_





**2021-2022**

**Athletic Pass Order Form**

**Adult Pass - \$75.00 per person**

**or**

**Family Pass - \$175.00**

- Admission to all HIGH SCHOOL AND JUNIOR HIGH regular season Home games (tournaments not included)
- *If your child attends MCS, admission to home games is free.*

A popular, economic and convenient way to cheer on our athletes!

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Number of passes: \_\_\_\_\_ Name(s) on pass(es): \_\_\_\_\_

Total amount: \_\_\_\_\_

Total amount will be billed to your FACTS account

Please fill out and return to the Central Office- Attention Ariel Dials