Ohio High School Athletic Association  
and OHSAA Member Schools  

IMPLEMENTATION OF NFHS PLAYING RULES CHANGES  
RELATED TO CONCUSSION AND CONCUSED ATHLETES AND  
RETURN TO PLAY PROTOCOL  

In its various sports playing rules, the National Federation of High Schools (NFHS) has implemented a standard rule change in all sports dealing with concussions in student-athletes. The basic rule in all sports (which may be worded slightly differently in each rule book due to the nature of breaks in time intervals at contests in different sports) states:

Any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion (such as loss of consciousness, headache, dizziness, confusion, or balance problems) shall be immediately removed from the contest and shall not return to play until cleared by an appropriate health-care professional. (Please see NFHS Suggested Guidelines for Management of Concussion in the Appendix in the back of each NFHS Rules Book).

It is important for all adults involved in interscholastic athletics to recognize the potential for catastrophic injury and even death from concussions. Thus it is extremely important that each coach, administrator, contest official and medical support personnel review their responsibilities in protecting students.

Last year the OHSAA Board of Directors adopted a sports regulation which incorporated the NFHS rules change. This regulation reads:

Any athlete who exhibits signs, symptoms or behaviors consistent with a concussion (such as loss of consciousness, headache, dizziness, confusion or balance problems) shall be immediately removed from the contest and shall not return to play until cleared with written authorization by an appropriate health care professional. In Ohio, an “appropriate health care professional” shall be a physician, as authorized under ORC Chapter 4731 and includes both doctors of medicine (M.D.) and doctors of osteopathy (D.O.) and an athletic Trainer, licensed under ORC Chapter 4755.

In January, 2011, the OHSAA Board of Directors has further defined the following parameters to guide OHSAA licensed officials, medical personnel and member school representatives in implementing this change.

1. What are the “signs, symptoms, or behaviors consistent with a concussion”? The National Federation rule lists some of the signs, symptoms and behaviors consistent with a concussion. The U.S. Department of Human Services, Centers for Disease Control and Prevention has published the following lists of signs, symptoms and behaviors that are consistent with a concussion:

<table>
<thead>
<tr>
<th>SIGNS OBSERVED BY OTHERS</th>
<th>SYMPTOMS REPORTED BY ATHLETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appears dazed or stunned</td>
<td>Headache</td>
</tr>
<tr>
<td>Is confused about assignment</td>
<td>Nausea</td>
</tr>
<tr>
<td>Forgets plays</td>
<td>Balance problems or dizziness</td>
</tr>
<tr>
<td>Is unsure of game, score, or opponent</td>
<td>Double or fuzzy vision</td>
</tr>
<tr>
<td>Moves clumsily</td>
<td>Sensitivity to light or noise</td>
</tr>
<tr>
<td>Answers questions slowly</td>
<td>Feeling sluggish</td>
</tr>
<tr>
<td>Loses consciousness</td>
<td>Feeling foggy or groggy</td>
</tr>
<tr>
<td>Shows behavior or personality changes</td>
<td>Concentration or memory problems</td>
</tr>
<tr>
<td>Cannot recall events prior to hit</td>
<td>Confusion</td>
</tr>
<tr>
<td>Cannot recall events after hit</td>
<td></td>
</tr>
</tbody>
</table>

2. Who is responsible for administering this new rule?  
All adults who have responsibilities and duties in the interscholastic athletics environment are responsible: coaches, contest official, administrators and medical personnel.

3. What is the role of coaches in administering this new rule?  
- Coaches are to review and know the signs and symptoms of concussion and to prohibit any athlete who displays these signs or symptoms from participating in a practice or a contest.
- Coaches are not medical professionals and have no authority to determine whether or not a student has sustained a concussion. The coach is responsible for insuring that the student’s parents are notified and the student is referred to a medical professional.

4. What is the role of contest officials in administering the new rule?  
- Officials are to review and know the signs and symptoms of concussion and to direct immediate removal of any athlete who displays these signs or symptoms,
• An official shall not permit the athlete who has been removed under this rule to return to competition without written medical authorization presented to the head official.
• If a contest official is aware that a student has been permitted to return to competition without written authorization from a physician or licensed athletic trainer, that official shall immediately stop play and remove that student from competition and report the incident to the Ohio High School Athletic Association.
• Note that officials are not medical professionals and have no authority to determine whether or not student has sustained a concussion. The official is responsible for directing removal when he or she observes signs and symptoms that may indicate a student is concussed.

5. Who decides if an athlete has not been concussed (has had a concussion) and/or who has recovered from a concussion?
• Only an MD (Medical Doctor), DO (Doctor of Osteopathy), or LAT (Licensed Athletic Trainer) is empowered to make the onsite determination that an athlete has not received a concussion.
• If any one of these individuals has answered that "yes" there has been a concussion, that decision is final.

6. Can an athlete return to play on the same day as he/she receives a concussion?
• No, under no circumstances can that athlete return to play that day.
• When in doubt, hold them out.
• If the event continues over multiple days, then the designated event physician has ultimate authority over return to play decisions.
• However, if the health care professional (MD, DO or LAT) has evaluated the athlete, who has been removed from competition due to exhibiting the signs and symptoms of a concussion, and has determined that the athlete did not sustain a concussion, that student may return to play with the submission of the written authorization by the health care professional.
• The written authorization shall be submitted to the school administration; however, if there is no administrator on site at the competition, the authorization may be held by the host site manager or the head coach.

7. Once the day has concluded, who can issue authorization to return to practice / competition in the sport?
• Once a concussion has been diagnosed by one of the above listed on site providers, only an MD, DO or LAT can authorize subsequent return to play, and such authorization shall be in writing to the administration of the school. This written RTP authorization shall be kept at the school until the statute of limitations expires, which is four years from the date of the student’s 18th birthday.
• School administration shall then notify the coach as to the permission to return to practice or play.

8. What should be done after the student is cleared by an appropriate health care professional?
• After a clearance has been issued, the student’s actual return to practice and play should follow a graduated protocol.
• The National Federation has included the following graduated protocol in its Suggested Guidelines for Management of Concussion in Sports: (This is simply a suggested protocol. The appropriate health care professional who issues the clearance may wish to establish a different graduated protocol.)

Medical Clearance RTP Protocol
1. No exertional activity until asymptomatic.
2. When the athlete appears clear, begin low-impact activity such as walking, stationary bike, etc.
3. Initiate aerobic activity fundamental to specific sport such as skating or running, and may also begin progressive strength training activities.
4. Begin Non-contact skill drills specific to sport such as dribbling, fielding, batting, etc.
5. Full contact in practice setting.
6. Game play/competition
   o ATHLETE MUST REMAIN ASYMPTOMATIC TO PROGRESS TO THE NEXT LEVEL. (It is often suggested that an athlete not be allowed to progress more than one level per day.)
   o IF SYMPTOMS RECUR, ATHLETE MUST RETURN TO PREVIOUS LEVEL AND SHOULD BE REEVALUATED BY AN APPROPRIATE HEALTH CARE PROFESSIONAL.
   o MEDICAL CHECK SHOULD OCCUR BEFORE CONTACT.(Final written clearance from the medical professional shall be obtained before the athlete engages in any unrestricted or full contact activity)

9. Fundamental Reminder about this change
• It has always been the ultimate responsibility of the coaching staff, in all sports, to ensure that players are only put into practice or contests if they are physically capable of performing; however, all adults involved in the conduct of interscholastic competition have responsibilities in this endeavor.
The NFHS has developed a new 20-minute online coach education course – *Concussion in Sports – What You Need to Know*, the NFHS Suggested Guidelines for Management of Concussion in Sports brochure, the NFHS Sports Medicine Handbook, materials from the CDC “Heads Up” program and other materials should all be made available to officials, parents, students and schools.

The Centers for Disease Control and Prevention has a publication entitled “Heads up to Schools: Know your Concussion ABC’s” – A Fact Sheet for Teachers, Counselors and School Professionals, available on its web site. Click onto [www.cdc.gov/concussion](http://www.cdc.gov/concussion) to obtain this valuable publication that will assist teachers and other school personnel in making accommodations for students returning to school after a concussion.

The following form may be used by schools to educate parents and students about this issue:

**INSERT SCHOOLNAME HERE**

Concussion Information Form

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

**Symptoms may include one or more of the following:**

- Headaches
- “Pressure in head”
- Nausea or vomiting
- Neck pain
- Balance problems or dizziness
- Blurred, double, or fuzzy vision
- Sensitivity to light or noise
- Feeling sluggish or slowed down
- Feeling foggy or groggy
- Drowsiness
- Change in sleep patterns
- Amnesia
- “Don’t feel right”
- Fatigue or low energy
- Sadness
- Nervousness or anxiety
- Irritability
- More emotional
- Confusion
- Concentration or memory problems (forgetting game plays)
- Repeating the same question/comment

**Signs observed by teammates, parents and coaches include:**

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays poor coordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can’t recall events prior to hit
- Can’t recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

Adapted from the CDC and the 3rd International Conference in Sport
What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion shall be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one (second impact syndrome). This can lead to prolonged recovery, or even to severe brain swelling with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often underreport symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete’s safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. You should also inform your child’s coach if you think that your child may have a concussion. Remember its better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to: http://www.cdc.gov/ConcussionInYouthSports/

_____________________________       _____________________________       _____________
Student-athlete Name Printed        Student-athlete Signature        Date

_____________________________     ______________________________       _____________
Parent or Legal Guardian Printed            Parent or Legal Guardian Signature                Date
Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2012-2013

HISTORY FORM

(Note: This form is to be filled out by the student and parent prior to seeing the medical examiner. The medical examiner should keep this form in the chart.)

Date of Exam ________________________________________________________________

Name ___________________________ Age ______ Grade ______ School _____

Sex ______ Date of birth __________________________

MEDICAL QUESTIONS

Yes No

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?

27. Have you ever used an inhaler or taken asthma medicine?

28. Is there anyone in your family who has asthma?

29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?

30. Do you have groin pain or a painful bulge or hernia in the groin area?

31. Have you had infectious mononucleosis (mono) within the past month?

32. Do you have any rashes, pressure sores, or other skin problems?

33. Have you had a herpes (cold sores) or MRSA (staph) skin infection?

34. Have you ever had a head injury or concussion?

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?

36. Do you have a history of seizure disorder or epilepsy?

37. Do you have headaches with exercise?

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?

39. Have you ever been unable to move your arms or legs after being hit or falling?

40. Have you ever become ill while exercising in the heat?

41. Do you get frequent muscle cramps when exercising?

42. Do you or someone in your family have sickle cell trait or disease?

43. Have you ever had an eating disorder?

44. Have you had an eye injury?

45. Do you wear glasses or contact lenses?

46. Do you wear protective eyewear, such as goggles or a face shield?

47. Do you worry about your weight?

48. Are you trying to gain or lose weight? Has anyone recommended that you do?

49. Are you on a special diet or do you avoid certain types of foods?

50. Have you ever had an eating disorder?

51. Do you have any concerns that you would like to discuss with a doctor?

FEMALES ONLY

52. Have you ever had a menstrual period?

53. How old were you when you had your first menstrual period?

54. How many periods have you had in the last 12 months?

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 ____________

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THE ATHLETE WITH SPECIAL NEEDS:
SUPPLEMENTAL HISTORY FORM

Date of Exam ______________________________________________________________________________________

Name _________________________________________________________________________

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

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

Explain "yes" answers here

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

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

Explain "yes" answers here

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:_________________________
**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet or use condoms?
   - Do you consume energy drinks?

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

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**EXAMINATION**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>□ Male</th>
<th>□ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>(</td>
<td>(</td>
<td>Pulse</td>
</tr>
<tr>
<td>Vision R 20/</td>
<td>L20/</td>
<td>Corrected</td>
<td>□ Y □ N</td>
</tr>
</tbody>
</table>

**MEDICAL**

- **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

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CLEARANCE FORM
Preparticipation Physical Evaluation 2012-2013

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 preparticipation 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 __________________________

______________________________ 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 preparticipation 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 __________________________
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 2012-2013

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.
2012-2013 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 brochure entitled “Your Athletic Eligibility,” 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 web site at 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 of time 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 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 transported via ambulance to the nearest hospital.

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 Post Secondary Enrollment Option, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility.

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 competition due to a suspected concussion, he or she will be unable to return to competition that day without the written authorization from a physician (M.D. or D.O.) or an athletic trainer which indicates that the student has not been concussed.

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

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<tr>
<th>Student’s Signature</th>
<th>Birth date</th>
<th>Grade in School</th>
<th>Date</th>
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<th>Parent’s or Guardian’s Signature</th>
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