



**PARA-SWIMMING SPORTS VERIFICATION FORM**

The purpose of this form is to declare an athlete’s eligibility for OHSAA para-swimming events in accordance with the criteria adopted by the Board of Directors and referenced in accordance with USA Para-Swimming guidelines. A copy of this form, which shall be submitted on a yearly basis, must be sent to the OHSAA and the original kept on permanent file with the athlete’s high school. This form must be submitted no later than 5:00PM on Sunday February 8, 2026.

**PART ONE: ATHLETE INFORMATION**

Name \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_  
Last First MI

**PART TWO: HIGH SCHOOL INFORMATION**

Name \_\_\_\_\_ Head Coach \_\_\_\_\_

Address \_\_\_\_\_, OH \_\_\_\_\_  
Street City Zip

I certify that the above-named athlete meets all OHSAA eligibility requirements of age, residency, and academics.

\_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of HS Principal OR Athletic Director

Name of Assistant (if any) who will accompany the student-athlete \_\_\_\_\_

**PART THREE: PHYSICIAN’S CERTIFICATION (May not be a relative of the athlete)**

I certify that I examined the above-named athlete applicant on \_\_\_\_\_ (Date), certify that he/she meets the OHSAA Minimal Disability Criteria listed below and in the OHSAA Para-Swimming Event Eligibility Rules and Regulations for each category.

Diagnosis:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Printed name of Physician

\_\_\_\_\_  
Signature of Physician

**PART FOUR: CATEGORIES FOR PARA-SWIMMERS – PHYSICIAN TO CHECK ONE**

\_\_\_\_\_ **CATEGORY ONE** – Non-ambulatory (uses a wheelchair) with limited use of all four extremities

\_\_\_\_\_ **CATEGORY TWO** – Dwarfism, multiple limb deficiencies, ambulatory with assistance, can use a wheelchair with a high functioning upper body