

**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.**

**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