The purpose of this form is to declare an athlete’s eligibility for OHSAA wheelchair track and field events in accordance with Section 2.0 of Appendix A, Eligibility and Minimal Disability Criteria (see pp. 11-12). A copy of this form 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

Address ________________________________________________________________________________,OH
Street        City      State             Zip

PART TWO: HIGH SCHOOL INFORMATION

Name ____________________________________________ Head Coach __________________________

Address ________________________________________________________________________________,OH
Street        City      State             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

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

I certify that the above athlete applicant was examined by myself on _________________(Date) and meets the OHSAA Minimal Disability Criteria listed in Appendix A, Section 2.0 (pages 11-12) of the OHSAA Wheelchair Event Eligibility Rules and Regulations.

Diagnosis: ______________________________________________________________________________________________
                                                                                              ______________________________________________________________________________________________
                                                                                              ______________________________________________________________________________________________

____________________________________________________ ________________________________________________
Printed name of Physician OR Classifier                          Signature of Physician OR Classifier

Address ________________________________________________________________________________,
Street       City          State                 Zip
Phone:   _______________________________________ Email:  ____________________________________________