



**OSMA / OHSAA SKIN CONDITION  
EVALUATION & AUTHORIZATION TO COMPETE IN  
HIGH SCHOOL WRESTLING**



**TO: PHYSICIAN, M.D. OR D.O.**

From National Federation Wrestling Rules: If a participant is suspected of having a communicable skin disease or any other condition that makes participation appear inadvisable, his coach shall provide written documentation from a physician stating that the suspected disease is not communicable and that the athlete's participation would not be harmful to his opponent. This document shall be furnished at the weigh-in or upon arrival at the site of the dual meet or tournament.

***Covering a communicable skin condition is not acceptable and does not make the wrestler eligible to participate.***

*( Please use ink )*

Please draw and describe skin condition(s) of: \_\_\_\_\_  
and answer all questions on this form. *(name of wrestler)*

1. Indicate the specific location of the suspected skin condition *(on the figures below)*



2. Describe the approximate size and color of the above condition  
*(example: it is about the size of a nickel, red in color; it is about two inches in diameter, blotchy red)*

\_\_\_\_\_

\_\_\_\_\_

3. Do you believe this skin condition is currently contagious? Circle one: YES NO

4. If contagious, when will it be safe (i.e. no longer communicable) for him to resume wrestling? Please list a calendar date: \_\_\_ / \_\_\_ / \_\_\_

5. Technical name of skin condition (diagnosis): \_\_\_\_\_

6. Name and dosage of medication used, if any: \_\_\_\_\_

7. This authorization covers the above diagrammed and described condition only and expires on: \_\_\_ / \_\_\_ / \_\_\_

***UNLESS SPECIFIED, THIS AUTHORIZATION EXPIRES TEN (10) DAYS FROM THE DATE OF EXAM***

Print Physician's name \_\_\_\_\_ Today's date \_\_\_ / \_\_\_ / \_\_\_

Physician's address \_\_\_\_\_

Physician's phone \_\_\_\_\_

Physician's signature \_\_\_\_\_