***ansas State High School Activities Association***

# PRE-PARTICIPATION PHYSICAL EVALUATION

### PPE is required annually and shall not be taken earlier than May 1 preceding the school year for which it is applicable.

HISTORY FORM *(Pages 1 & 2 should be filled out by the student and* ***parent/guardian*** *prior to the physical examination)*

PPE

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | \*Sex at Birth |  | Age | Date of birth |
| Grade | School |  |  | Sport(s) |  |
| Home Address |  |  |  | Phone | - |
| Personal physician |  |  | Parent Email |  |  |

\*In cases of disorder of sexual development (DSD), designation of sex at birth may be delayed for a period of time until medical providers and family can make the appropriate determination.

List past and current medical conditions:

Have you ever had surgery? If yes, list all past surgical procedures:

Medicines and Allergies:

Please list all of the prescription and over-the-counter medicines, inhalers, and supplements (herbal and nutritional) that you are currently taking:

No Medications

Do you have any allergies?

Medicines

Yes No If yes, please identify specific allergy below.

Pollens

Food

Stinging Insects

What was the reaction?

Explain “Yes” answers at the end of this form. Circle questions if you don’t know the answer.

|  |  |  |
| --- | --- | --- |
| GENERAL QUESTIONS: | YES | NO |
| 1. Do you have any concerns that you would like to discuss with your provider? |  |  |
| 2. Has a provider ever denied or restricted your participation in sports for any reason? |  |  |
| 3. Do you have any ongoing medical issues or recent illness? |  |  |
| 4. Have you ever spent the night in the hospital? |  |  |
| HEART HEALTH QUESTIONS ABOUT YOU: | YES | NO |
| 5. Have you ever passed out or nearly passed out during or after exercise? |  |  |
| 6. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise? |  |  |
| 7. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? |  |  |
| 8. Has a doctor ever told you that you have any heart problems? |  |  |
| 9. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. |  |  |
| 10. Do you get light-headed or feel shorter of breath than your friends during exercise? |  |  |
| 11. Have you ever had a seizure? |  |  |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY: | YES | NO |
| 12. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (includ- ing drowning or unexplained car crash)? |  |  |
| 13. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? |  |  |
| 14. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? |  |  |
| BONE AND JOINT QUESTIONS: | YES | NO |
| 15. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? |  |  |
| 16. Have you ever had any broken or fractured bones or dislocated joints? |  |  |
| 17. Have you ever had an injury that required x-rays, MRI, CT scan, injections or therapy? |  |  |
| 18. Have you ever had any injuries or conditions involving your spine (cervical, thoracic, lumbar)? |  |  |
| 19. Do you regularly use, or have you ever had an injury that required the use of a brace, crutches, cast, orthotics or other assistive device? |  |  |
| 20. Do you have a bone, muscle, ligament, or joint injury that bothers you? |  |  |
| 21. Do you have any history of juvenile arthritis, other autoimmune disease or other congenital genetic conditions (e.g., Downs Syndrome or Dwarfism)? |  |  |

Kansas State High School Activities Association, *601 SW Commerce Place | PO Box 495 | Topeka, KS 66601 | 785-273-5329*

1

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| MEDICAL QUESTIONS: | | | | YES | NO |
| 22. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | | |  |  |
| 23. Have you ever used an inhaler or taken asthma medicine? | | | |  |  |
| 24. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organs? | | | |  |  |
| 25. Do you have groin or testicle pain, a bump, a painful bulge or hernia in the groin area? | | | |  |  |
| 26. Have you had infectious mononucleosis (mono)? | | | |  |  |
| 27. Do you have any recurring skin rashes or skin infection that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? | | | |  |  |
| 28. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | | | |  |  |
| If yes, how many? | | | | | |
| What is the longest time it took for full recovery? | | | | | |
| When were you last released? | | | | | |
| 29. Do you have headaches with exercise? | | | |  |  |
| 30. Have you ever had numbness, tingling, weakness in your arms (including stingers/burners) or legs, or been unable to move your arms or legs after being hit or falling? | | | |  |  |
| 31. Have you ever become ill while exercising in the heat? | | | |  |  |
| 32. Do you get frequent muscle cramps when exercising? | | | |  |  |
| 33. Do you or does someone in your family have sickle cell trait or disease? | | | |  |  |
| 34. Have you ever had or do you have any problems with your eyes or vision? | | | |  |  |
| 35. Do you wear protective eyewear, such as goggles or a face shield? | | | |  |  |
| 36. Do you worry about your weight? | | | |  |  |
| 37. Are you trying to or has anyone recommended that you gain or lose weight? | | | |  |  |
| 38. Are you on a special diet or do you avoid certain types of foods or food groups? | | | |  |  |
| 39. Have you ever had an eating disorder? | | | |  |  |
| 40. How do you currently identify your gender? | M | F | Other | | |
| 41. Over the last 2 weeks, how often have you been bothered by any of the following problems? *(check box)* | | NOT AT ALL | SEVERAL DAYS | OVER HALF THE DAYS | NEARLY EVERY DAY |
| Feeling nervous, anxious, or on edge | | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | | 0 | 1 | 2 | 3 |
| Little interest or pleasure in doing things | | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | | 0 | 1 | 2 | 3 |
| *(A sum of 3 or more is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes) Patient Health Questionnaire Version 4 (PHQ-4)* | | | | | |
| FEMALES ONLY: |  |  | YES NO | | |
|  | | | |  |  |
| 42. Have you ever had a menstrual period? | | | |  |  |
| 43. If yes, are you experiencing any problems or changes with athletic participation (i.e., irregularity, pain, etc.)? | | | |  |  |
| 44. How old were you when you had your first menstrual period? | | | | | |
| 45. When was your most recent menstrual period? | | | | | |
| 46. How many menstrual periods have you had in the past 12 months? | | | | | |

Explain all Yes answers here from the previous two pages.

By signing below, I certify that all information provided on pages 1-2 is accurate and true. I understand that any false or misleading information provided as part

X

of this exam could result in disqualification from activity participation for my child and my child’s teams.

X Signature of parent/guardian

Signature of student-athlete Date

Date

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PHYSICAL EXAMINATION FORM |  | | | |
| Name |  |  |  | Date of birth |
| Date of recent immunizations: Td | Tdap | Hep B | Varicella | HPV Meningococcal |
| 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, e-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 enhancing 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 and adhere to safe sex practices?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14 of History Form).
3. Per Kansas statute, any school athlete who has sustained a concussion shall not return to competition or practice until the athlete is evaluated by a healthcare provider and the healthcare provider (MD or DO only) provides such athlete a written clearance to return to play or practice.
4. Per Kansas Statute, students indicated as biological male at birth may not participate on girls teams.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| EXAMINATION | | | | | | |
| Height | Weight | Male Female | BP *(reference gender/height/age chart)\*\*\*\** / ( / ) | | | Pulse |
| Vision R 20/ | L 20/ | Corrected: Yes | No |  |  | |
| MEDICAL | | | | NORMAL | ABNORMAL FINDINGS | |
| Appearance  - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | | | |  |  | |
| Eyes/ears/nose/throat  - Pupils equal, Gross Hearing | | | |  |  | |
| Lymph nodes | | | |  |  | |
| Heart \*  - Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | | | |  |  | |
| Pulses  - Simultaneous femoral and radial pulses | | | |  |  | |
| Lungs | | | |  |  | |
| Abdomen | | | |  |  | |
| Skin  - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus* aureus (MRSA),  or tinea corporis | | | |  |  | |
| Neurological\*\*\* | | | |  |  | |
| Genitourinary (optional-males only)\*\* | | | |  |  | |
| MUSCULOSKELETAL | | | | NORMAL | ABNORMAL FINDINGS | |
| Neck | | | |  |  | |
| Back | | | |  |  | |
| Shoulder/arm | | | |  |  | |
| Elbow/forearm | | | |  |  | |
| Wrist/hand/fingers | | | |  |  | |
| Hip/thigh | | | |  |  | |
| Knee | | | |  |  | |
| Leg/ankle | | | |  |  | |
| Foot/toes | | | |  |  | |
| Functional  - e.g. double-leg squat test, single-leg squat test, and box drop or step drop test | | | |  |  | |

\*Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those. \*\*Consider GU exam if in ap- propriate medical setting. Having third party present is recommended. \*\*\*Consider cognitive evaluation or baseline neuropsychiatric testing if a significant history of concussion. \*\*\*\*Flynn JT, Kaelber DC, Baker-Smith CM, et al. Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents. Pediatrics. 2017;140(3):e20171904.

I acknowledge I have reviewed the preceding patient history pages and have performed the above physical examination on the student named on this form.

XName of healthcare provider (print/type)

Date

Signature of healthcare provider , MD, DO, DC, PA-C, APRN

*(please circle one)*

Address Phone

***Healthcare Providers: You must complete the Medical Eligibility Form on the following page***

## MEDICAL ELIGIBILITY FORM

Name Date of birth

Medically eligible for all sports without restriction

Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

Medically eligible for certain sports

Not medically eligible pending further evaluation Not medically eligible for any sports

Recommendations:

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form, except as indicated above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of healthcare provider (print or type): Date: Signature of healthcare provider: , MD, DO, DC, or PA-C, APRN Address: Phone:

X

## SHARED EMERGENCY INFORMATION

Allergies:

Medications:

Other information:

Emergency contacts:

## Parent or Guardian Consent

To be eligible for participation in interscholastic athletics/spirit groups, a student must have on file with the superintendent or principal, a signed statement by a physician, chiropractor, physician's assistant who has been authorized to perform the examination by a Kansas licensed supervising physician or an advanced practice registered nurse who has been authorized to perform this examination by a Kansas licensed supervising physician, certifying the student has passed an adequate physical exami- nation and is physically fit to participate (See KSHSAA Handbook, Rule 7). A complete history and physical examination must be performed annually before a student participates in KSHSAA interscholastic athletics/cheerleading.

I do not know of any existing physical or any additional health reasons that would preclude participation in activities. I certify that the answers to the questions in the HISTORY part of the Preparticipation Physical Examination (PPE), are true and accurate. I understand that any false or misleading information provided as part of this exam could result in disqualification from activity participation for my child and my child’s teams. I approve participation in activities. I hereby authorize release to the KSHSAA, school nurse, certified athletic trainer (whether employee or independent contractor of the school), school administrators, coach and medical provider of information contained in this document. Upon written request, I may receive a copy of this document for my own personal health care records.

I acknowledge that there are risks of participating, including the possibility of catastrophic injury. I hereby give my consent for the above student to compete in KSHSAA approved activities, and to accompany school representatives on school trips and receive emergency medical treatment when necessary. It is understood that neither the KSHSAA nor the school assumes any responsibility in case of accident. The undersigned agrees to be responsible for the safe return of all equipment issued by the school to the student.

XSignature of parent/guardian

Date

Parent/guardian phone:

*The parties to this document agree that an electronic signature is intended to make this writing effective and binding and to have the same force and effect as the use of a manual signature.*

Kansas State High School Activities Association, *601 SW Commerce Place | PO Box 495 | Topeka, KS 66601 | 785-273-5329*

Adapted from PPE: Preparticipation Physical Evaluation, 5th Edition, © 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncom-

mercial, educational purposes with acknowledgment. 4