



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.

Pages 1-4 are 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 noncommercial, educational purposes with acknowledgment.

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

Name	Date of Birth	Age	*Sex at 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.

Students and parents/guardian should complete pages 1-2 together. 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 (including 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)?		

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Name _____ Date of Birth _____

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? <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 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
<i>(A sum of 3 or more is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes)</i>					
<i>Patient Health Questionnaire Version 4 (PHQ-4)</i>					
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

Parents/Students: Complete the Medical Eligibility Form (page 4) and the KSHSAA Eligibility Checklist (page 5).

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PHYSICAL EXAMINATION FORM

Name _____	Date of birth _____
Date of recent immunizations:	Td _____ Tdap _____ Hep B _____ Varicella _____ HPV _____ Meningococcal _____

PHYSICIAN REMINDERS

1. Review the health history on pages 1 & 2 AND the student information section on page 4, prior to the exam.
2. Consider additional questions on more sensitive issues

<ul style="list-style-type: none"> - 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? 	<ul style="list-style-type: none"> - 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?
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3. Consider reviewing questions on cardiovascular symptoms (questions 5-14 of History Form).
4. 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.
5. Per Kansas Statute, students indicated as biological male at birth may not participate on girls teams.

EXAMINATION			
Height	Weight	Male <input type="checkbox"/> Female <input type="checkbox"/>	BP (reference gender/height/age chart)**** / (/) Pulse
Vision R 20/	L 20/	Corrected: Yes <input type="checkbox"/> No <input type="checkbox"/>	
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 <i>Staphylococcus aureus</i> (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 appropriate 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.

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

KSHSAA PRE-PARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM - PARENT/STUDENT SECTION

Student Name: _____ Date of Birth: _____ Sex at Birth: _____ Grade: _____
 Home Address: _____ Height: _____ Weight: _____
 Home Phone: _____ Parent Email: _____
 Emergency Contact(s): _____ Phone: _____

STUDENT INFORMATION	YES	NO		YES	NO
Do you have any current or past medical conditions in which the school should be aware?			Have you ever had a heat stroke, or become sick while exercising in the heat?		
Have you ever had surgery?			Do you have asthma?		
Do you have any allergies?			If yes, do you use an inhaler?		
Do you have any cardiac/heart issues?			Do you or a family member have sickle cell trait or disease?		
Have you ever had a seizure?			Are you missing any organs?		
Have you ever had a concussion?			Have you ever spent the night in a hospital?		
Do you have diabetes?			Are you currently taking any prescription medications?		
If yes, do you take insulin?			Are you currently taking any nutritional supplements?		

Please explain any "YES" answers above:

HEALTHCARE PROVIDER SECTION

- Medically eligible for all sports without restriction.
- Medically eligible for all sports without restriction. **Recommend further evaluation/treatment (see comments below*).**
- Medically eligible for certain sports **(see comments below*).**
- Not medically eligible for any sports. Not medically eligible for any sports pending further evaluation **(see comments below*).**

*Comments/Recommendations:

I have reviewed all patient information provided and completed the preparticipation physical examination of the student named on this form. 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 of Examination: _____
 Signature of healthcare provider: _____ MD, DO, DC, PA-C, APRN
 Provider address: _____ Provider phone: _____

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 this examination by their state's law and licensing body, or an advanced practice registered nurse who has been authorized to perform this examination by their state's law and licensing body, certifying the student has passed an adequate physical examination 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 my child's medical providers, school medical personnel (whether employee or independent contractor of the school), school administration, school coaches, and KSHSAA the information contained in this document. I acknowledge I may choose to only submit to my child's school this medical eligibility page in lieu of the entire history and physical exam 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.

Signature of parent/guardian: _____ Date: _____ 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.