



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)

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? Yes No If yes, please identify specific allergy below.
 Medicines _____ 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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever spent the night in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU:	YES	NO
5. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury that required x-rays, MRI, CT scan, injections or therapy?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had any injuries or conditions involving your spine (cervical, thoracic, lumbar)?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you have a bone, muscle, ligament, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you have any history of juvenile arthritis, other autoimmune disease or other congenital genetic conditions (e.g., Downs Syndrome or Dwarfism)?	<input type="checkbox"/>	<input type="checkbox"/>

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MEDICAL QUESTIONS:		YES	NO		
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?		<input type="checkbox"/>	<input type="checkbox"/>		
23. Have you ever used an inhaler or taken asthma medicine?		<input type="checkbox"/>	<input type="checkbox"/>		
24. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organs?		<input type="checkbox"/>	<input type="checkbox"/>		
25. Do you have groin or testicle pain, a bump, a painful bulge or hernia in the groin area?		<input type="checkbox"/>	<input type="checkbox"/>		
26. Have you had infectious mononucleosis (mono)?		<input type="checkbox"/>	<input type="checkbox"/>		
27. Do you have any recurring skin rashes or skin infection that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		<input type="checkbox"/>	<input type="checkbox"/>		
28. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		<input type="checkbox"/>	<input type="checkbox"/>		
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?		<input type="checkbox"/>	<input type="checkbox"/>		
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?		<input type="checkbox"/>	<input type="checkbox"/>		
31. Have you ever become ill while exercising in the heat?		<input type="checkbox"/>	<input type="checkbox"/>		
32. Do you get frequent muscle cramps when exercising?		<input type="checkbox"/>	<input type="checkbox"/>		
33. Do you or does someone in your family have sickle cell trait or disease?		<input type="checkbox"/>	<input type="checkbox"/>		
34. Have you ever had or do you have any problems with your eyes or vision?		<input type="checkbox"/>	<input type="checkbox"/>		
35. Do you wear protective eyewear, such as goggles or a face shield?		<input type="checkbox"/>	<input type="checkbox"/>		
36. Do you worry about your weight?		<input type="checkbox"/>	<input type="checkbox"/>		
37. Are you trying to or has anyone recommended that you gain or lose weight?		<input type="checkbox"/>	<input type="checkbox"/>		
38. Are you on a special diet or do you avoid certain types of foods or food groups?		<input type="checkbox"/>	<input type="checkbox"/>		
39. Have you ever had an eating disorder?		<input type="checkbox"/>	<input type="checkbox"/>		
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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Not being able to stop or control worrying	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Little interest or pleasure in doing things	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Feeling down, depressed, or hopeless	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
<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?		<input type="checkbox"/>	<input type="checkbox"/>		
43. If yes, are you experiencing any problems or changes with athletic participation (i.e., irregularity, pain, etc.)?		<input type="checkbox"/>	<input type="checkbox"/>		
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 of this exam could result in disqualification from activity participation for my child and my child's teams.

X Signature of parent/guardian _____ Date _____
 X Signature of student-athlete _____ Date _____

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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. Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you drink alcohol or use any other drugs?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Have you ever taken anabolic steroids or used any other performance enhancing supplement?
 - Do you feel safe at your home or residence?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - Do you wear a seat belt, use a helmet and adhere to safe sex practices?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
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 <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.

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

Name of healthcare provider (print/type) _____ Date _____

X 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

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

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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: _____

X Signature of healthcare provider: _____, MD, DO, DC, or PA-C, APRN

Address: _____ Phone: _____

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 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 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.

X Signature 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.

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