



Pre-Participation Physical Evaluation

PPE

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

HISTORY FORM (should be filled out by the student and parent/guardian prior to the physical examination)

Name _____ Sex _____ Age _____ Date of birth _____
 Grade _____ School _____ Sport(s) _____
 Home Address _____ Phone _____
 Personal physician _____ Parent Email _____

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

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 below. Circle questions you don't know the answers to.

| General Questions | Yes | No |
|---|-----|----|
| 1. Have you had a medical condition or injury since your last check up or sports physical? | | |
| 2. Has a doctor ever denied or restricted your participation in sports for any reason? | | |
| 3. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____ | | |
| 4. Have you ever spent the night in the hospital? | | |
| 5. Have you ever had surgery? | | |
| Heart Health Questions About You | Yes | No |
| 6. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| 7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 8. Does your heart ever race or skip beats (irregular beats) during exercise? | | |
| 9. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Other: _____ | | |
| 10. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) | | |
| 11. Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| 12. Have you ever had an unexplained seizure? | | |
| 13. Do you get more tired or short of breath more quickly than your friends during exercise? | | |
| Heart Health Questions About Your Family | Yes | No |
| 14. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? | | |
| 15. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | |
| 16. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | |
| 17. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | |
| Bone And Joint Questions | Yes | No |
| 18. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | |
| 19. Have you ever had any broken or fractured bones or dislocated joints? | | |
| 20. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | |
| 21. Have you ever had a stress fracture? | | |
| 22. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | | |
| 23. Do you regularly use a brace, orthotics, or other assistive device? | | |
| 24. Do you have a bone, muscle, or joint injury that bothers you? | | |
| 25. Do any of your joints become painful, swollen, feel warm, or look red? | | |
| 26. Do you have any history of juvenile arthritis or connective tissue disease? | | |

| Medical Questions | Yes | No |
|--|-----|----|
| 27. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 28. Have you ever used an inhaler or taken asthma medicine? | | |
| 29. Is there anyone in your family who has asthma? | | |
| 30. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 31. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 32. Have you had infectious mononucleosis (mono) within the last month? | | |
| 33. Do you have any rashes, pressure sores, or other skin problems? | | |
| 34. Have you had a herpes or MRSA skin infection? | | |
| 35. Have you ever had a head injury or concussion? If yes, how many? _____ What is the longest you've been held out of sports or school? _____ When were you last released? _____ | | |
| 36. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 37. Do you have a history of seizure disorder? | | |
| 38. Do you have headaches with exercise? | | |
| 39. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling (Stinger/Burner/Pinched Nerve)? | | |
| 40. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 41. Have you ever become ill while exercising in the heat? | | |
| 42. Do you get frequent muscle cramps when exercising? | | |
| 43. Do you or someone in your family have sickle cell trait or disease? | | |
| 44. Have you had any problems with your eyes or vision? | | |
| 45. Have you had any eye injuries? | | |
| 46. Do you wear glasses or contact lenses? | | |
| 47. Do you wear protective eyewear, such as goggles or a face shield? | | |
| 48. Do you worry about your weight? | | |
| 49. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 50. Are you on a special diet or do you avoid certain types of foods? | | |
| 51. Have you ever had an eating disorder? | | |
| 52. Do you have any concerns that you would like to discuss with a doctor? | | |
| Females Only | Yes | No |
| 53. Have you ever had a menstrual period? | | |
| 54. If yes, are you experiencing any problems or changes with athletic participation (i.e., irregularity, pain, etc.)? | | |
| 55. How old were you when you had your first menstrual period? | | |
| 56. How many periods have you had in the last 12 months? | | |

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ 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 ever feel sad, hopeless, depressed, or anxious?
- Do you feel safe at your home or residence?
- Have you ever tried 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 supplement?

• Have you ever taken any supplements to help you gain or lose weight or improve your performance?

• Do you wear a seat belt and use a helmet?

2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

| EXAMINATION | | Male <input type="checkbox"/> Female <input type="checkbox"/> | | BP (reference gender/height/age chart)*** | / | (/) | Pulse |
|---|--------|---|--|---|---|-------|-------|
| Height | Weight | | | | | | |
| 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, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | | | | | | |
| Eyes/ears/nose/throat • Pupils equal • Gross Hearing | | | | | | | |
| Lymph nodes | | | | | | | |
| Heart * • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI) | | | | | | | |
| Pulses • Simultaneous femoral and radial pulses | | | | | | | |
| Lungs | | | | | | | |
| Abdomen | | | | | | | |
| Genitourinary (males only)** | | | | | | | |
| Skin • HSV, lesions suggestive of MRSA, tinea corporis | | | | | | | |
| Neurologic*** | | | | | | | |
| MUSCULOSKELETAL | NORMAL | ABNORMAL FINDINGS | | | | | |
| Neck | | | | | | | |
| Back | | | | | | | |
| Shoulder/arm | | | | | | | |
| Elbow/forearm | | | | | | | |
| Wrist/hand/fingers | | | | | | | |
| Hip/thigh | | | | | | | |
| Knee | | | | | | | |
| Leg/ankle | | | | | | | |
| Foot/toes | | | | | | | |
| Functional • Duck-walk, single leg hop | | | | | | | |

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. **Consider GU exam if in private setting. Having third party present is recommended.

***Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

****Chart found in: The Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents. Pediatric BP mobile application can also be used.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
- For any sports
- For certain sports _____
- *Reason _____

Recommendations _____

I have examined the above-named student and student history and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

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

Address _____ Phone _____

Signature of healthcare provider _____, MD, DO, DC, PA-C, APRN
(please circle one)

Student's Name _____

(PLEASE PRINT CLEARLY)

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.

The annual history and the physical examination shall not be taken earlier than May 1 preceding the school year for which it is applicable. The KSHSAA recommends completion of this evaluation by athletes/cheerleaders at least one month prior to the first practice to allow time for correction of deficiencies and implementation of conditioning recommendations.

Parent or Guardian Consent

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 approve participation in activities. I hereby authorize release to the KSHSAA, school nurse, certified athletic trainer, 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.

**The above named student and I have read the
KSHSAA Eligibility Check List
and how to retain eligibility information listed in this form.**

For Middle/Junior High and Senior High School Students to Determine Eligibility When Enrolling

If a **negative** response is given to any of the following questions, this enrollee should contact his/her administrator in charge of evaluating eligibility. This should be done before the student is allowed to attend his/her first class and prior to the first activity practice. If questions still exist, the school administrator should telephone the KSHSAA for a final determination of eligibility. (*Schools shall process a Certificate of Transfer Form T-E on all transfer students.*)

YES NO

1. Are you a bona fide student in **good standing** in school? (If there is a question, your principal will make that determination.)
2. Did you **pass at least five new subjects (those not previously passed)** last semester? (*The KSHSAA has a minimum regulation which requires you to pass at least five subjects of unit weight in your last semester of attendance.*)
3. Are you planning to **enroll in at least five new subjects (those not previously passed)** of unit weight this coming semester? (*The KSHSAA has a minimum regulation which requires you to enroll and be in attendance in at least five subjects of unit weight.*)
4. Did you **attend** this school or a feeder school in your district last semester? (*If the answer is "no" to this question, please answer Sections a and b.*)
 - a. Do you reside with your parents?
 - b. If you reside with your parents, have they made a permanent and bona fide move into your school's attendance center?

The student/parent authorizes the school to release to the KSHSAA student records and other pertinent documents and information for the purpose of determining student eligibility. The student/parent also authorizes the school and the KSHSAA to publish the name and picture of student as a result of participating in or attending extra-curricular activities, school events and KSHSAA activities or events.

Parent or Guardian's Signature

Date

Student's Signature

Date

Birth Date

Grade

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after sustaining a concussion, regardless of how mild it seems or how quickly symptoms clear, without written medical clearance from a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO). Close observation of the athlete should continue for several hours. You should also inform your child's coach if you think that your child may have a concussion Remember it is better to miss one game than miss the whole season. **When in doubt, the athlete sits out!**

Cognitive Rest & Return to Learn

The first step to concussion recovery is cognitive rest. This is essential for the brain to heal. Activities that require concentration and attention such as trying to meet academic requirements, the use of electronic devices (computers, tablets, video games, texting, etc.), and exposure to loud noises may worsen symptoms and delay recovery. Students may need their academic workload modified while they are initially recovering from a concussion. Decreasing stress on the brain early on after a concussion may lessen symptoms and shorten the recovery time. This may involve staying home from school for a few days, followed by a lightened school schedule, gradually increasing to normal. Any academic modifications should be coordinated jointly between the student's medical providers and school personnel. No consideration should be given to returning to physical activity until the student is fully integrated back into the classroom setting and is symptom free. Rarely, a student will be diagnosed with post-concussive syndrome and have symptoms that last weeks to months. In these cases, a student may be recommended to start a non-contact physical activity regimen, but this will only be done under the direct supervision of a healthcare provider.

Return to Practice and Competition

The Kansas School Sports Head Injury Prevention Act provides that if an athlete suffers, or is suspected of having suffered, a concussion or head injury during a competition or practice, the athlete must be immediately removed from the competition or practice and cannot return to practice or competition until a Health Care Professional has evaluated the athlete and provided a written authorization to return to practice and competition. The KSHSAA recommends that an athlete not return to practice or competition the same day the athlete suffers or is suspected of suffering a concussion. The KSHSAA also recommends that an athlete's return to practice and competition should follow a graduated protocol under the supervision of the health care provider (MD or DO).

For current and up-to-date information on concussions you can go to:

<http://www.cdc.gov/concussion/HeadsUp/youth.html>

<http://www.kansasconcussion.org/>

For concussion information and educational resources collected by the KSHSAA, go to:

<http://www.kshsaa.org/Public/General/ConcussionGuidelines.cfm>

Student-athlete Name Printed

Student-athlete Signature

Date

Parent or Legal Guardian Printed

Parent or Legal Guardian Signature

Date