



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	Medical Questions	Yes	No
1. Have you had a medical condition or injury since your last check up or sports physical?			27. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Has a doctor ever denied or restricted your participation in sports for any reason?			28. Have you ever used an inhaler or taken asthma medicine?		
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: _____			29. Is there anyone in your family who has asthma?		
4. Have you ever spent the night in the hospital?			30. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
5. Have you ever had surgery?			31. Do you have groin pain or a painful bulge or hernia in the groin area?		
Heart Health Questions About You	Yes	No	32. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever passed out or nearly passed out DURING or AFTER exercise?			33. Do you have any rashes, pressure sores, or other skin problems?		
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			34. Have you had a herpes or MRSA skin infection?		
8. Does your heart ever race or skip beats (irregular beats) during exercise?			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? _____		
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: _____			36. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			37. Do you have a history of seizure disorder?		
11. Do you get lightheaded or feel more short of breath than expected during exercise?			38. Do you have headaches with exercise?		
12. Have you ever had an unexplained seizure?			39. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling (Stinger/Burner/Pinched Nerve)?		
13. Do you get more tired or short of breath more quickly than your friends during exercise?			40. Have you ever been unable to move your arms or legs after being hit or falling?		
Heart Health Questions About Your Family	Yes	No	41. Have you ever become ill while exercising in the heat?		
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)?			42. Do you get frequent muscle cramps when exercising?		
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?			43. Do you or someone in your family have sickle cell trait or disease?		
16. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			44. Have you had any problems with your eyes or vision?		
17. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			45. Have you had any eye injuries?		
Bone And Joint Questions	Yes	No	46. Do you wear glasses or contact lenses?		
18. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			47. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had any broken or fractured bones or dislocated joints?			48. Do you worry about your weight?		
20. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			49. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Have you ever had a stress fracture?			50. Are you on a special diet or do you avoid certain types of foods?		
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)			51. Have you ever had an eating disorder?		
23. Do you regularly use a brace, orthotics, or other assistive device?			52. Do you have any concerns that you would like to discuss with a doctor?		
24. Do you have a bone, muscle, or joint injury that bothers you?			Females Only	Yes	No
25. Do any of your joints become painful, swollen, feel warm, or look red?			53. Have you ever had a menstrual period?		
26. Do you have any history of juvenile arthritis or connective tissue disease?			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			
Height	Weight	Male <input type="checkbox"/> Female <input type="checkbox"/>	I 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, 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			
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)