Instructions for completing the NCHSAA Student-Athlete Pre-Participation Physical Evaluation (PPE)

In order to be medically eligible for participation in practice or in interscholastic athletic contests, a student must complete a pre-participation physical evaluation (PPE) and provide medical eligibility documentation to the school.

There are three sections that need to be completed:

- 1. History Form (Pages 1-2)
 - a. This form is completed by the student-athlete and his / her parent or guardian.
 - b. Both the athlete and a parent or guardian shall sign this form.
- 2. Physical Examination Form (Page 3)
 - a. This section is completed by and signed by a licensed medical professional (MD, DO, NP, or PA-C).
 - b. The physical exam should include a thorough review of the history form. The licensed medical professional should ask any clarifying questions or discuss any areas left blank on the medical history during the physical exam.
 - c. This form should be signed on the date that the physical examination was completed.
- 3. Medical Elig<mark>i</mark>bility (Page 4)
 - a. This section is completed by and signed by the licensed medical professional who reviewed the history form and completed the physical exam.
 - b. The licensed medical provider should complete the Shared Emergency Information based on findings from the history form and the physical examination.
 - c. This form should also be signed on the date that the physical examination was completed.



PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name:	Date of birth:
	Sport(s):
Sex assigned at birth (F or M):	
Have you had COVID-19? (optional, chec	k one): □Y □N
Have you been immunized for COVID-19	? (optional, check one): □ Y □ N If yes, have you had: □ One shot □ Two shots □ Three shots □ Booster date(s)
List past and current medical conditions	
Have you ever had surgery? If yes, list all p	past surgical procedures
Medicines and supplements: List all currer	nt prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).
Do you have any allergies? If yes, please	list all your allergies (ie, medicines, pollens, food, stinging insects).
	HQ-4) u been bothered by any of the following problems? (Circle response.)

	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	
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(A sum of \geq 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

(Exp	IERAL QUESTIONS lain "Yes" answers at the end of this form. Circle stions if you don't know the answer.)	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?		
HEA	RT HEALTH QUESTIONS ABOUT YOU	Yes	No
4.	Have you ever passed out or nearly passed out during or after exercise?		
5.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6.	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7.	Has a doctor ever told you that you have any heart problems?		
8.	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)				
9.	Do you get light-headed or feel shorter of brea than your friends during exercise?	ath		
10.	Have you ever had a seizure?			
HEA	RT HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	Yes	No
11.	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)?			
12.	Does anyone in your family have a genetic heart problem such as hypertrophic cardio- myopathy (HCM), Marfan syndrome, arrhyth- mogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13.	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BON	IE AND JOINT QUESTIONS	Yes	No
14.	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?		
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?		
Med	VICAL QUESTIONS	Yes	No
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17.	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?			
21.	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22.	Have you ever become ill while exercising in the heat?		
23.	Do you or does someone in your family have sickle cell trait or disease?		
24.	Have you ever had or do you have any problems with your eyes or vision?		

MEC	DICAL QUESTIONS (CONTINUED)		Yes	No
25.	Do you worry about your weight?			
26. Are you trying to or has anyone recommended that you gain or lose weight?				
27. Are you on a special diet or do you avoid certain types of foods or food groups?				
28. Have you ever had an eating disorder?				
MENSTRUAL QUESTIONS (optional) N/A			Yes	No
29.	Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?				
31. When was your most recent menstrual period?				
32. How many periods have you had in the past 12 months?				

Explain "Yes" answers here.

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

Signature of athlete:	
Signature of parent or guardian:	
Date:	

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PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____

PHYSICIAN REMINDERS

Date of birth:

- ${\sf I}$. 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 use condoms?
- 2. Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Cor	rected: 🗆 Y 🛛	3 N
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, and throat		
Pupils equalHearing		
-		
Lymph nodes Heart ^a		
 Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Abdomen		
Skin		
 Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or 	-	
tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional		
 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 his	tory or examination	ation findings, or a combi-
nation of those.		

Name of health care professional (print or type):	Date of <u>exam:</u>		
Address:	Phone:		
Signature of health care professional:	, MD, DO, NP, or		

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PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

N	h	m	Δ	•

□ 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

 $\hfill\square$ 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. A copy of the p hysical examination findings are on record in my office and can be made available to the school at the request of the parents. 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).

Date of birth:

Name of health care professional (print or type):	Date <u>of exam</u> :	
Address:	Phone:	
Signature of health care professional:		, MD, DO, NP, or PA
SHARED EMERGENCY INFORMATION		
Allergies:		
Medications:		
Other information:		
Emergency contacts:		

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