KANSAS STATE HIGH SCHOOL ACTIVITIES ASSOCIATION
PO Box 495, 520 SW 27th St.; Topeka, KS 66601-0495; (785) 235-9201

PPE

HISTORY

PRE-PARTICIPATION PHYSICAL EVALUATION

TO BE COMPLETED ANNUALLY BY EVERY PARTICIPANT AND PARENT OR GUARDIAN

Name ______ Sex ______ Age ______ Date of birth ______

Grade ______ School ______ Sport(s) ______

Address ______ Phone ( ) ______

Personal physician ______

In case of emergency, contact:

Name ______ Relationship ______ Phone (H) ______ (W) ______

STUDENT/PARENT/GUARDIAN - answer questions below PRIOR TO EXAMINATION by physician. Explain "YES" answers in space below. Circle the number of the questions you do not know.

	YES	NO	
1.	☐	☐	Have you had a medical illness or injury since your last check up or sports physical?
	☐	☐	Do you have an ongoing or chronic illness?
2.	☐	☐	Have you ever been hospitalized overnight?
	☐	☐	Have you ever had surgery?
3.	☐	☐	Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?
	☐	☐	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
4.	☐	☐	Do you have any allergies *(for example, to pollen, medicine, food, or stinging insects)*? Have you ever had a rash or hives develop during or after exercise?
5.	☐	☐	Have you ever passed out during or after exercise?
	☐	☐	Have you ever been dizzy during or after exercise?
	☐	☐	Have you ever had chest pain during or after exercise?
	☐	☐	Do you get tired more quickly than your friends do during exercise?
	☐	☐	Have you ever had racing of your heart or skipped heartbeats?
	☐	☐	Have you had high blood pressure or high cholesterol?
	☐	☐	Have you ever been told you have a heart murmur?
	☐	☐	Has any family member or relative died of heart problems or of sudden death before age 50?
	☐	☐	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?
	☐	☐	Has a physician ever denied or restricted your participation in sports for any heart problems?
6.	☐	☐	Do you have any current skin problems (for example itching, rashes, acne, warts, fungus, or blisters)?
7.	☐	☐	Have you ever had a head injury or concussion? When? ______ How many? ______
	☐	☐	Have you ever been knocked out, become unconscious, or lost your memory?
	☐	☐	Have you ever had a seizure?
	☐	☐	Have you ever had numbness or tingling in your arms, hands, legs, or feet?
	☐	☐	Have you ever had a stinger, burner, or pinched nerve?
8.	☐	☐	Have you ever become ill from exercising in the heat?
9.	☐	☐	Do you cough, wheeze, or have trouble breathing during or after activity?
	☐	☐	Do you have asthma?
	☐	☐	Do you have seasonal allergies requiring medical treatment?
10.	☐	☐	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position *(for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)*?
11.	☐	☐	Have you had any problems with your eyes or vision?
	☐	☐	Do you wear glasses, contacts, or protective eyewear?
12.	☐	☐	Have you ever had a sprain, strain, fracture or dislocation of a muscle, tendon, bone or joint? *If yes, check appropriate box and explain below.*

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm		☐ Foot

	YES	NO	
13.	☐	☐	Do you want to weigh more or less than you do now?
	☐	☐	Do you lose weight regularly to meet weight requirements for your sport?

FEMALES ONLY

	YES	NO	
14.	☐	☐	Have you begun menstruation?
	☐	☐	If yes, are you ever experiencing any problem (i.e., irregularity, pain, etc.)?

IDENTIFY "YES" ANSWERS *(by number)*

______

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Rev. 1/00

PHYSICAL EXAMINATION

PRE-PARTICIPATION PHYSICAL EVALUATION

Name ______________________ Date of Birth ______________________

Height ______ Weight ______ Tanner Stage I II III IV V Pulse ______ Blood Pressure ______ / ______

Vision R 20/ ______ L 20/ ______ Corrected: Y N Pupils: Equal ______ Unequal ______

Record date of most recent immunizations (shot) for Td ______________________

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE

☐ Cleared for all activities

☐ Not cleared for: ______________________

Reason: ______________________

Recommendations: ______________________

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I HEREBY CERTIFY THAT I AM QUALIFIED BY TRAINING AND EXPERIENCE TO PROPERLY PERFORM THE EXAMINATION AND MAKE THE EVALUATION REFLECTED ON THIS FORM

Name of physician *(print/type)* ______________________ Date ______________

Address ______________________ Phone ( ) ______________

Signature of physician ______________________ , MD, DO, DC or RPA