KANSAS STATE HIGH SCHOOL ACTIVITIES ASSOCIATION
PO Box 495, 601 SW Commerce Place; Topeka, KS 66601-0495; (785) 273-5329

PPE

HISTORY
PRE-PARTICIPATION PHYSICAL EVALUATION

Name Sex Age Date of birth

TO BE COMPLETED ANNUALLY BY EVERY PARTICIPANT AND PARENT OR GUARDIAN

Grade School Sport(s)

Address Phone ( )

Personal physician Parent Email

In case of emergency, contact:

Name Relationship Phone (H) (W)

PPE shall not be taken earlier than May 1 preceding the school year for which it is applicable.
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 use an inhaler before excercise?
	☐	☐	Do you have seasonal allergies requiring medical treatment?

	YES	NO	
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

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?
14.	☐	☐	Has a doctor told you or a family member that you are at risk for blood disorders? Ex: Sickle Cell, etc…
15.	☐	☐	Were you born without or are you missing a kidney, testicle or any other organs?
16	☐	☐	Do you feel that you have fatigue or increased shortness of breath with activity?
17.	☐	☐	Do you have any concerns that you would like to discuss with the doctor?

FEMALES ONLY

18.	☐	☐	Have you begun menstruation?
	☐	☐	If yes, are you ever experiencing any problem (i.e., irregularity, pain, etc.)?

IDENTIFY "YES" ANSWERS *(by number)*

_____

_____

_____

_____

_____

_____

_____

Rev. 3/09

PHYSICAL EXAMINATION

PRE-PARTICIPATION PHYSICAL EVALUATION

Name Date of Birth

Height Weight Pulse Blood Pressure /

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

Date of recent immunizations: Td Tdap Hep B

Varicella HPV Meningococcal

	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:

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 PA

(please circle)