

Instructions for Completing the NCHSAA Student-Athlete Preparticipation Physical Evaluation (PPE)

In order to be medically eligible for participation in practice or in interscholastic athletic contests, a student must have a completed NCHSAA PPE and submit it to the school. The PPE is four (4) pages in length and includes the **History Form**, the **Physical Examination Form**, and the **Medical Eligibility Form**.

The PPE **History Form** (pages 1-2) is completed and signed by the parent or legal custodian on behalf of the student-athlete. The completed and signed PPE History Form must then be presented to the examining Licensed Medical Professional (LMP) (physician licensed to practice medicine (MD/DO), nurse practitioner or physician assistant) for review when they fill out the Physical Examination Form.

The completed PPE **Physical Examination Form** (page 3) is <u>signed</u> and <u>dated</u> by the LMP who performed the examination. The physical examination builds on information obtained in the medical history.

The PPE **Medical Eligibility Form** (page 4), which is also <u>signed</u> and <u>dated</u> by the LMP, indicates the student-athlete is either medically eligible or not medically eligible for sports participation.



# Student-Athlete COVID Questionnaire

Student-Athlete's Name: \_\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

COVID RELATED QUESTIONS ABOUT THE STUDENT-ATHLETE	YES	NO	NA
<ol> <li>Since January 1, 2020 have you been told that you have had a positive test for COVID-19, <b>OR</b> have you been told by a medical professional, your school, or local health department that you have had to quarantine (stay home) due to concern that you had COVID-19 symptoms?</li> </ol>			
2. If the answer to 1 was "Yes", has the required Return to Play Form: COVID-19 Infection Medical Clearance Releasing The Student-Athlete to Resume Full Participation in Athletics been completed?			
3. Have you been fully vaccinated against COVID?			

# ■ PREPARTICIPATION PHYSICAL EVALUATION



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

Name:		Date of birth:	
Date of examination:			
Sex: M/F			
List past and current medical conditions.			
Have you ever had surgery? If yes, list all past surgical p	procedures.		

Medicines and supplements: List all current 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).

Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)							
	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			
$1^{1}$ sum of $>3$ is considered positive on either	r subscale lauestier	s 1 and 2 or aug	stions 3 and 41 for scro	oning purposes )			

(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. e questions 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)		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	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 cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic poly- morphic ventricular tachycardia (CPVT)?		
<ol> <li>Has anyone in your family had a pacemaker or an implanted defibrillator before age 35</li> </ol>		



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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	ICAL QUESTIONS	Yes	No
16.	Do you cough, wheeze, or have difficult breathing during or after exercise?		
17.	Are you missing a kidney, an eye, a testicle (males), 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 prob- lems with your eyes or vision?		

MEDICAL 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?		
FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?		
30. How old were you when you had your firs 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

- 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, 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?
  - ٠ 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).

EXAMIN	ATION								
Height:				Weight:					
BP:	/ (	/	)	Pulse:	Vision: R 20/	L 20/	Correc	ted: 🗆 Y 🛛	□N
MEDICAL	-							NORMAL	ABNORMAL FINDINGS
	ın stigmato				hed palate, pectus excavatum, ara aortic insufficiency	achnodactyly, hype	rlaxity,		
Eyes, ears • Pupils • Hearin		d throa	t						
Lymph no	des								
Heartª ● Murm	urs (auscu	ltation s	tandin	ıg, auscultatio	on supine, and ± Valsalva maneu	iver)			
Lungs									
Abdomen	1								
tinea	corporis	virus (H	SV), le	esions sugges	tive of methicillin-resistant Staphy	vlococcus aureus (N	NRSA), or		
Neurolog									
MUSCUL	OSKELETA	L						NORMAL	ABNORMAL FINDINGS
Neck									
Back									
Shoulder	and arm								
Elbow an	d forearm								
Wrist, ha	nd, and fir	nger							
Hip and t	high								
Knee									
Leg and c	inkle								
Foot and	toes								
Functiona • Doubl		t test, si	ngle-le	eg squat test,	and box drop or step drop test				
nation of th	nose.		-		diography, referral to a cardiolog ):	-		-	ation findings, or a combi te:
Address: _			•						
Signature o	of health c	are prof	ession						, MD, DO, NP, or PA

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Date of birth:

#### ■ PREPARTICIPATION PHYSICAL EVALUATION

# **MEDICAL ELIGIBILITY FORM**

Name:	Date of birth:	_
Medically eligible for all sports without restriction		
Medically eligible for all sports without restriction with recommendation	is for further evaluation or treatment of	_
Medically eligible for certain sports		_
, , , , , , , , , , , , , , , , , , , ,		_
□ Not medically eligible pending further evaluation		_
Not medically eligible for any sports		
Recommendations:		-
I have examined the student named on this form and completed th apparent clinical contraindications to practice and can participate examination findings are on record in my o fice and can be made arise after the athlete has been cleared for participation, the physi and the potential consequences are completely explained to the at	in the sport(s) as outlined on this form. A copy of available to the school at the request of the parer ician may rescind the medical eligibility until the p	the physical nts. If conditions
Name of health care professional (print or type):	Date:	
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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