



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 signed and dated 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 signed and dated 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 |
|--|--------------------------|--------------------------|--------------------------|
| 1. Since January 1, 2020 have you been told that you have had a positive test for COVID-19, OR 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If the answer to 1 was "Yes", has the required <i>Return to Play Form: COVID-19 Infection Medical Clearance Releasing The Student-Athlete to Resume Full Participation in Athletics</i> been completed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been fully vaccinated against COVID? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



■ 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: _____

Date of examination: _____ Sport(s): _____

Sex: M/F _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical 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 |

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

| GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle 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? | | | | |
| HEART 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) | | | 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 polymorphic ventricular tachycardia (CPVT)? | | | | |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | | | | |



| BONE 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? | | |
| MEDICAL 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 (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 problems 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 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: _____ Date of birth: _____

PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

| EXAMINATION | | |
|---|---------|--|
| Height: | Weight: | |
| BP: / (/) | Pulse: | Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N |
| MEDICAL | NORMAL | ABNORMAL FINDINGS |
| Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | | |
| Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing | | |
| Lymph nodes | | |
| Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | | |
| Lungs | | |
| Abdomen | | |
| Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (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 <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test | | |

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA



■ 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 recommendations 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 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 physical 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).

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: _____





■ EVALUACIÓN FÍSICA PREVIA A LA PARTICIPACIÓN

FORMULARIO DE HISTORIAL CLÍNICO

Nota: Complete y firme este formulario (con la supervisión de sus padres si es menor de 18 años) antes de acudir a su cita.

Nombre: _____ Fecha de nacimiento: _____

Fecha del examen médico: _____ Deporte(s): _____

Sexo que se le asignó al nacer (F, M o intersexual): _____ ¿Con cuál género se identifica? (F, M u otro): _____

Mencione los padecimientos médicos pasados y actuales que haya tenido. _____

¿Alguna vez se le practicó una cirugía? Si la respuesta es afirmativa, haga una lista de todas sus cirugías previas. _____

Medicamentos y suplementos: Enumere todos los medicamentos recetados, medicamentos de venta libre y suplementos (herbolarios y nutricionales) que consume. _____

¿Sufre de algún tipo de alergia? Si la respuesta es afirmativa, haga una lista de todas sus alergias (por ejemplo, a algún medicamento, al polen, a los alimentos, a las picaduras de insectos). _____

Cuestionario sobre la salud del paciente versión 4 (PHQ-4)

Durante las últimas dos semanas, ¿con qué frecuencia experimentó alguno de los siguientes problemas de salud? (Encierre en un círculo la respuesta)

| | Ningún día | Varios días | Más de la mitad de los días | Casi todos los días |
|--|------------|-------------|-----------------------------|---------------------|
| Se siente nervioso, ansioso o inquieto | 0 | 1 | 2 | 3 |
| No es capaz de detener o controlar la preocupación | 0 | 1 | 2 | 3 |
| Siente poco interés o satisfacción por hacer cosas | 0 | 1 | 2 | 3 |
| Se siente triste, deprimido o desesperado | 0 | 1 | 2 | 3 |

(Una suma ≥ 3 se considera positiva en cualquiera de las subescalas, [preguntas 1 y 2 o preguntas 3 y 4] a fin de obtener un diagnóstico).

PREGUNTAS GENERALES

(Dé una explicación para las preguntas en las que contestó "Sí", en la parte final de este formulario. Encierre en un círculo las preguntas si no sabe la respuesta).

| | Sí | No |
|--|----|----|
| 1. ¿Tiene alguna preocupación que le gustaría discutir con su proveedor de servicios médicos? | | |
| 2. ¿Alguna vez un proveedor de servicios médicos le prohibió o restringió practicar deportes por algún motivo? | | |
| 3. ¿Padece algún problema médico o enfermedad reciente? | | |

PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR

| | Sí | No |
|---|----|----|
| 4. ¿Alguna vez se desmayó o estuvo a punto de desmayarse mientras hacía, o después de hacer, ejercicio? | | |

PREGUNTAS SOBRE SU SALUD

CARDIOVASCULAR (CONTINUACIÓN)

| | Sí | No |
|--|----|----|
| 5. ¿Alguna vez sintió molestias, dolor, compresión o presión en el pecho mientras hacía ejercicio? | | |
| 6. ¿Alguna vez sintió que su corazón se aceleraba, palpataba en su pecho o latía intermitentemente (con latidos irregulares) mientras hacía ejercicio? | | |
| 7. ¿Alguna vez un médico le dijo que tiene problemas cardíacos? | | |
| 8. ¿Alguna vez un médico le pidió que se hiciera un examen del corazón? Por ejemplo, electrocardiografía (ECG) o ecocardiografía. | | |
| 9. Cuando hace ejercicio, ¿se siente mareado o siente que le falta el aire más que a sus amigos? | | |
| 10. ¿Alguna vez tuvo convulsiones? | | |

| PREGUNTAS SOBRE LA SALUD CARDIOVASCULAR DE SU FAMILIA | | |
|---|----|----|
| | Si | No |
| 11. ¿Alguno de los miembros de su familia o pariente murió debido a problemas cardíacos o tuvo una muerte súbita e inesperada o inexplicable antes de los 35 años de edad (incluyendo muerte por ahogamiento o un accidente automovilístico inexplicable)? | | |
| 12. ¿Alguno de los miembros de su familia padece un problema cardíaco genético como la miocardiopatía hipertrófica (HCM), el síndrome de Marfan, la miocardiopatía arritmogénica del ventrículo derecho (ARVC), el síndrome del QT largo (LQTS), el síndrome del QT corto (SQTS), el síndrome de Brugada o la taquicardia ventricular polimórfica catecolaminérgica (CPVT)? | | |
| 13. ¿Alguno de los miembros de su familia utilizó un marcapasos o se le implantó un desfibrilador antes de los 35 años? | | |
| PREGUNTAS SOBRE LOS HUESOS Y LAS ARTICULACIONES | | |
| | Si | No |
| 14. ¿Alguna vez sufrió una fractura por estrés o una lesión en un hueso, músculo, ligamento, articulación o tendón que le hizo faltar a una práctica o juego? | | |
| 15. ¿Sufre alguna lesión ósea, muscular, de los ligamentos o de las articulaciones que le causa molestia? | | |
| PREGUNTAS SOBRE CONDICIONES MÉDICAS | | |
| | Si | No |
| 16. ¿Tose, sibila o experimenta alguna dificultad para respirar durante o después de hacer ejercicio? | | |
| 17. ¿Le falta un riñón, un ojo, un testículo (en el caso de los hombres), el bazo o cualquier otro órgano? | | |
| 18. ¿Sufre dolor en la ingle o en los testículos, o tiene alguna protuberancia o hernia dolorosa en la zona inguinal? | | |
| 19. ¿Padece erupciones cutáneas recurrentes o que aparecen y desaparecen, incluyendo el herpes o <i>Staphylococcus aureus</i> resistente a la meticilina (MRSA)? | | |

| PREGUNTAS SOBRE CONDICIONES MÉDICAS (CONTINUACIÓN) | | |
|--|----|----|
| | Si | No |
| 20. ¿Alguna vez sufrió un traumatismo craneoencefálico o una lesión en la cabeza que le causó confusión, un dolor de cabeza prolongado o problemas de memoria? | | |
| 21. ¿Alguna vez sintió adormecimiento, hormigueo, debilidad en los brazos o piernas, o fue incapaz de mover los brazos o las piernas después de sufrir un golpe o una caída? | | |
| 22. ¿Alguna vez se enfermó al realizar ejercicio cuando hacía calor? | | |
| 23. ¿Usted o algún miembro de su familia tiene el rasgo drepanocítico o padece una enfermedad drepanocítica? | | |
| 24. ¿Alguna vez tuvo o tiene algún problema con sus ojos o su visión? | | |
| 25. ¿Le preocupa su peso? | | |
| 26. ¿Está tratando de bajar o subir de peso, o alguien le recomendó que baje o suba de peso? | | |
| 27. ¿Sigue alguna dieta especial o evita ciertos tipos o grupos de alimentos? | | |
| 28. ¿Alguna vez sufrió un desorden alimenticio? | | |
| UNICAMENTE MUJERES | | No |
| 29. ¿Ha tenido al menos un periodo menstrual? | | |
| 30. ¿A los cuántos años tuvo su primer periodo menstrual? | | |
| 31. ¿Cuándo fue su periodo menstrual más reciente? | | |
| 32. ¿Cuántos periodos menstruales ha tenido en los últimos 12 meses? | | |

Proporcione una explicación aquí para las preguntas en las que contestó "Si".

Por la presente declaro que, según mis conocimientos, mis respuestas a las preguntas de este formulario están completas y son correctas.

Firma del atleta: _____

Firma del padre o tutor: _____

Fecha: _____

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■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

| EXAMINATION | | |
|---|---------------|--|
| Height: _____ | Weight: _____ | |
| BP: _____ / _____ (_____ / _____) | Pulse: _____ | Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N |
| MEDICAL | NORMAL | ABNORMAL FINDINGS |
| Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | | |
| Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing | | |
| Lymph nodes | | |
| Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | | |
| Lungs | | |
| Abdomen | | |
| Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or <i>linea corporis</i> | | |
| 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 <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test | | |

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

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■ 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 recommendations 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 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 physical 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).

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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