PRE-PARTICIPATION PHYSICAL EVALUATION FORM (PPE)

The IHSAA Pre-participation Physical Evaluation (PPE) is the first and most important step in providing for the well-being of Indiana's high school athletes. The form is designed to identify risk factors prior to athletic participation by way of a thorough medical history and physical examination. The IHSAA, under the guidance of the Indiana State Medical Association's Committee on Sports Medicine, requires that the PPE Form be signed by a physician (MD or DO), nurse practitioner or physician assistant holding a license to practice in the State of Indiana. In order to assure that these rigorous standards are met, both organizations endorse the following require-ments for completion of the PPE Form:

1. The most current version of the IHSAA PPE Form must be used and may not be altered or modified in any manner.

2. The PPE Form must be signed by a physician (MD or DO), nurse practitioner or physician assistant only after the medical history is reviewed, the examination performed, and the PPE Form completed in its entirety. No pre-signed or pre-stamped forms will be accepted.

3. **SIGNATURES**
   - ❑ The signature must be hand-written. No signature stamps will be accepted.
   - ❑ The signature and license number must be affixed on page three (3).
   - ❑ The parent signatures must be affixed to the form on pages two (2) and five (5).
   - ❑ The student-athlete signature must be affixed to pages two (2) and five (5).

4. Distribution
   - ❑ History Form retained by Physician/Healthcare Provider
   - ❑ Examination Form and Consent and Release Form signed and returned to member school.

Your cooperation will help ensure the best medical screening for Indiana's high school athletes.

PREPARTICIPATION PHYSICAL
HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment. ***History Form is retained by physician/healthcare provider.***

Name: _____ Date of birth: _____

Date of examination: _____ Grade: _____

Sex assigned at birth (F, M, or intersex): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? It 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).

_____

Are your required vaccinations current? _____

Patient Health Questionnaire Version 4 (PHQ-4)

Overall, during the last 2 weeks, how often have you 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

(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 poly-morphic 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 Staphylococcus aureus (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, tingling, 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 food and 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: _____

MUST RETURN THIS PAGE TO ATHLETIC OFFICE (2024–2025)

PHYSICAL EXAMINATION

Valid Aril 1, 2024 - May 31, 2025

(Physical examination must be performed on or after April 1 by a health care professional holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) Rule 3-10

Name _____ Date of Birth _____ Grade _____ IHSAA Member School _____

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, chewing tobacco, snuff, or dip?
   - During the last 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 use any other appearance/performance 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 (questions 5-14)

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected? Y N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance		
• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insuffiency		
Eyes/ears/nose/throat		
• Pupils equal		
• Hearing		
Lymphnodes		
Heart		
• Murmurs (auscultation standing, supine, +/- Valsalva)		
Pulses		
• Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Skin		
• HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		

MUSCULOSKELETAL					
	NORMAL	**ABNORMAL FINDINGS**		**NORMAL**	**ABNORMAL FINDINGS**
Neck			Knee		
Back			Leg/ankle		
Shoulder/arm			Foot/toes		
Elbow/forearm			Functional		
Wrist/hand/fingers			• Duck-walk, single leg hop		
Hip/thigh					

☐ Cleared for all sports without restriction ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared ☐ Pending further evaluation ☐ For any sports

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Health Care Professional (print/type) _____ Date _____

Address _____ Phone _____ License # _____

Signature of Health Care Professional _____, MD, DO, PA, or NP (Circle one)