



August 12, 2022

Dear Physicians, Athletic Directors and School Medical Personnel:

The Committee on Sports Medicine of the Iowa Medical Society is updating the Pre-Participation Physical Evaluation (PPE) form starting the 2022-2023 sports seasons. This updated form was revised and created for the participants in Iowa High School Athletics in order to be most current in best practices of screening and identifying health concerns of the student athlete that are relevant to their safe participation. The information used for this update was from the [Pre-Participation Physical Evaluation, 5th Edition](#), published in 2019. The updated form and plans for transition were shared with the Iowa Association of School Boards for review and input prior to dissemination.

Below are some brief highlights of changes to the attached form:

- Expanded Format-The form is now 4 pages instead of 2 pages.
- Mental Health Screening
- Expanded Adolescent Safety Questions
- Updated Health Questions and Physical Examination
- Confidentiality and Format Changes

SPECIAL NOTE: Page 4 of this form is ALWAYS turned in to the school for participation/clearance and emergency contact information. This page can be used by any and all personnel of the school.

However, due to HIPAA/FERPA regulations, a licensed health care professional and confidential storage of the sports physical form pages 1 through 3 is necessary, if those pages are to be kept at the school and used for medical purposes. Otherwise, pages 1 through 3 can be kept with the provider who performs the Pre-participation Examination and a waiver should be signed for release of information by the student athlete and parent if this is required by the school for participation of the student athlete. (*Ref: 5th Edition of Pre-Participation Physical Examination, 2019, pgs 25-27*)

We appreciate your understanding in these updates and changes to mirror best practices in the Pre-Participation Examination. By working together in this, we can help to provide the safest environment for participation of our student athletes.

IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

Please complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____

Date of Birth: _____

Date of Examination: _____

Sport(s): _____

Home Address (Street, City, Zip): _____

School District: _____

Parent's/Guardian's Name: _____

Phone #: _____

Physician: _____

Phone #: _____

History Form:

List past and current medical conditions.

Have you ever had a 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 (to medicines, pollen, food, stinging insects, etc.)

PHQ-4: Over 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 Everyday
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)

SCORE: _____

In the section below, if you answer "yes" to any questions, please explain further in the space provided at the end of this form. Circle any questions you don't know the answer to.

General Questions:

Y N

- Do you have any concerns that you would like to discuss with your provider?
- Has a provider ever denied or restricted your participation in sport for any reason?
- Do you have any ongoing medical issues or recent illnesses?

Heart Health Questions:

Y N

- Have you ever passed out or nearly passed out during or after exercise?
- Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?
- Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?
- Has a doctor ever told you that you have any heart problems?
- Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography?
- Do you get lightheaded or feel shorter of breath than your friends during exercise?
- Do you have high blood pressure or high cholesterol?

Questions about your Family:

Y N

- 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)?
- 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)?
- Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?
- Does anyone in your family have asthma?

Bone and Joint Questions:

Y N

- 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?
- Have you had an X-ray, MRI, CT scan or physical therapy for any reason?
- Do you have a bone, muscle, ligament or joint injury that bothers you?
- Do you currently, or have you in the past worn orthotics, braces or protective equipment for any reason?

Medical Question:

Y N

- Do you cough, wheeze or have difficulty breathing during or after exercise?
- Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?
- Do you have groin or testicle pain or a painful bulge or hernia in the groin area?
- Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?
- Have you had a concussion? Or a head injury that caused confusion, a prolonged headache, or memory problems?
- Have you ever had a seizure?
- Do you get frequent headaches?
- 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?
- Have you ever become ill when exercising in the heat?
- Do you have sickle cell trait or disease? Or anyone in your family?
- Have you ever had or do you have any problems with your eyes or vision?
- Do you worry about your weight?
- Are you trying to or has anyone recommended that you gain or lose weight?
- Are you on a special diet or do you avoid certain types of foods or food groups?
- Have you ever had an eating disorder?

FEMALES only:

Y N

- Have you ever had a menstrual period?
- How old were you when you had your first menstrual period?
- When was your most recent menstrual period?
- How many periods have you had in the last 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: _____

Physical Examination *(To be filled out by medical provider)*

Consider additional questions as below:

Y N

- 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?
- Do you drink alcohol or use any other drugs?
- Have you taken prescriptions medications that were not yours or outside of their intended use?
- 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 and a helmet?
- Do you use condoms if you are sexually active?

EXAMINATION

Height: _____ Weight: _____

BP: _____ / _____ (_____ / _____) Pulse: _____ Vision: R 20/____ L 20/____ Corrected Y / 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 <ul style="list-style-type: none"> • Murmurs (auscultation standing, auscultation supine, and ± Valsalva) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> • Herpes Simplex Virus, lesions suggestive of MRSA or Tinea Corporis 		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder & Arm		
Elbow & Forearm		
Wrist, hand, and fingers		
Hip & Thigh		
Knee		
Leg & Ankle		
Foot & Toes		
Functional <ul style="list-style-type: none"> • May include: Duck Walk, Double-leg squat test, single-leg squat test, and box drop or step drop test 		

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

Medical Eligibility Form

Student Athlete Name: _____ Date of Birth: _____ Date of Examination: _____

I acknowledge and give consent for a copy of this entire form to be kept in the student's school record. I agree that should student's health change in any way that would alter this form that I will inform the school as soon as possible.

Signature of Parent or Guardian: _____ Date: _____

Shared Emergency Information *(To be filled out by athlete/athlete's caregiver)*

Allergies:

Medications:

Other Information:

Emergency Contacts:

<u>Name</u>	<u>Relationship</u>	<u>Contact Information</u>
_____	_____	_____
_____	_____	_____

Participation Eligibility *(To be filled out by medical provider)*

- Medically Eligible for 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 in this form. A copy of the physical examination findings 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 provider 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): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional:

Preparticipación Atlético Examen Físico, Actualización

Artículo VII 36.14 (1) Examen Físico. Todos los años cada estudiante (grados 7-12) presentará al supervisor del estudiante un certificado firmado por un médico y el cirujano licenciados, médico y cirujano osteopáticos, el osteópata, enfermero registrado avanzado (ARNP), ayudante de médico o médico calificado de la quiropráctica, al efecto que el estudiante se ha examinado y puede entrar seguramente en la competencia atlético. Este certificado de examen físico es válido para los propósitos de esta regla para uno (1) calendario año. Un periodo de gracia, no exceder treinta (30) días, es permitido para certificaciones expiradas de examen físico.

Cuestionario para la Participación Atlético (por favor escribe a máquina o imprime ordenadamente esta información)

Nombre _____ Masculino ___ Hembra ___ Fecha del nacimiento _____ Grado _____

Domicilio _____ Distrito Escolar _____

Nombre de padre/guardián _____ Fecha _____ Numero del teléfono _____

Médico de la familia _____ Teléfono del médico _____

HISTORIA DE LA SALUD (Las preguntas siguientes deben ser completadas por el estudiante-atleta con la ayuda de un padre o guardián. Un padre o el guardián son requeridos a firmar en al otro lado de esta forma después que el examen físico se completa.)

Si No ¿Tenga este estudiante tuvo cualquiera...

- 1 ___ ___ Alergia medicinas, al polen, los insectos, comida?
- 2 ___ ___ Enfermedad que dura más de una (1) semana?
- 3 ___ ___ El Asma o dificultad que respira durante ejercicio?
- 4 ___ ___ Enfermedad o la herida que es crónica o recurrente?
- 5 ___ ___ La Diabetes?
- 6 ___ ___ Epilepsia u otros ataques?
- 7 ___ ___ Llevar lentes o lentillas?
- 8 ___ ___ La infección del herpes o MRSA?
- 9 ___ ___ Hospitalizaciones (de noches o más largo)?
- 10 ___ ___ El Síndrome de Marfan?
- 11 ___ ___ Perdiendo órganos (ojo, un riñón, un testículo)?
- 12 ___ ___ La fiebre Reumática, el mononucleosis?
- 13 ___ ___ Las tomas o frecuente dolores de cabeza?
- 14 ___ ___ La cirugía?
- *****
- 15 ___ ___ Presión en el pecho, dolor o sensación de opresión con el ejercicio?
- 16 ___ ___ El mareo o desmayar con ejercicio?
- 17 ___ ___ Dolores de cabeza, mareos o desmayos durante, o después de hacer ejercicio?
- 18 ___ ___ Los problemas cardíacos (compitiendo, el murmullo, golpes saltados, la infección, etc.)?
- 19 ___ ___ La hipertensión o el colesterol alto?

Si No ¿Tenga este estudiante tuvo cualquiera...

- 20 ___ ___ La herida en la cabeza, la conmoción, la inconsciencia?
- 21 ___ ___ La herida en la cabeza, la conmoción, la inconsciencia?
- 22 ___ ___ El entumecimiento, sentir hormigueo, o la debilidad en armamentos o piernas con contacto?
- *****
- 23 ___ ___ El músculo severo obstaculiza o se enferma al ejercitar en el calor?
- *****
- 24 ___ ___ Fractura, la fractura por sobrecarga o articulación dislocada?
- 25 ___ ___ Las heridas que requieren el tratamiento médico?
- 26 ___ ___ La herida de rodilla o la cirugía de rodilla?
- 27 ___ ___ La herida del cuello?
- 28 ___ ___ Aparatos ortopédicos, aparatos ortopédicos, equipos de protección?
- 29 ___ ___ Otras heridas articulación graves?
- 30 ___ ___ Doloroso abultamiento o hernia en la ingle?
- 31 ___ ___ Rayos X, resonancia magnética, tomografía computarizada, terapia física?
- *****
- 32 ___ ___ Un médico ha negado nunca o restringido su participación en los deportes por cualquier razón?
- 33 ___ ___ ¿Tiene alguna duda que le gustaría discutir con su proveedor de atención médica?

Si No Historia de Familia

- 34 ___ ___ ¿En su familia tiene cualquiera síndrome de Marfan?
- 35 ___ ___ ¿Ha alguien de su familia murió de problemas cardíacos o cualquier motivo inesperado/inexplicada antes de la edad de 50 años?
- 36 ___ ___ ¿Alguien en su familia tiene un problema cardíaco, marcapasos o desfibriladores implantables?
- 37 ___ ___ ¿Tiene alguien en su familia había inexplicable desmayo, convulsiones, o cerca de ahogarse?
- 38 ___ ___ ¿Alguien en su familia tiene asma?
- 39 ___ ___ ¿Usted o alguien de su familia tienen rasgo de células falciformes o la enfermedad?

Utilice este espacio para explicar cualquiera del encima de numerado "sí" respuestas (preguntas #1-38) o para proporcionar información adicional: _____

40 ¿Es usted alérgico a cualquier prescripción o medicinas sin receta? Si sí, lista: _____

41 Lista todos medicinas que usted actualmente está tomando (incluir inhalantes de asma y EpiPens) y la condición que la medicina es para-
A _____ B _____ C _____

42 Año del último conocido- El tétano inyección _____ Vacunación de Meningitis _____ Vacunación de Influenza _____

43 ¿Qué es el más y menos usted ha pesado en el año pasado? Mayoría _____ Menos _____

44 ¿Está usted contento con su peso actual? Sí _____ No _____

PARA MUJERES SOLO-

1. ¿Cuántos años tenía cuando usted tuvo su primer período menstrual? _____

2. En el año pasado, ¿qué es el tiempo más largo que usted ha ido entre períodos menstruales? _____

Registro Físico del Examen (Ser completado por un médico de profesional licenciado como designado en el Artículo VII 36.14(1). Esta evaluación es de sólo determinar la prontitud para la participación de deporte. No se debe utilizar como un sustituto para exámenes regulares de salud.

Nombre de atleta _____ La altura _____ Peso _____

Pulso _____ Tensión _____ / _____ (Repita si anormal _____ / _____) la Visión R 20/ _____ L 20/ _____

	NORMALES	CONCLUSIONES ANORMALES	INICIALAN
1. La apariencia (esp. Marfan's)	_____	_____	_____
2. Los ojos/orejas/nariz/garganta	_____	_____	_____
3. El tamaño del alumno (Iguala/no igual)	_____	_____	_____
4. La boca & dientes	_____	_____	_____
5. El cuello	_____	_____	_____
6. Nodos de linfa	_____	_____	_____
7. El corazón (Parándose & Mintiendo)	_____	_____	_____
8. Pulsos (esp. Femoral)	_____	_____	_____
9. El pecho & pulmones	_____	_____	_____
10. El abdomen	_____	_____	_____
11. Pele	_____	_____	_____
12. Los genitales-Hernia	_____	_____	_____
13. El músculo esquelético-ROM, la fuerza, etc. (Vea las preguntas 24-28)	_____	_____	_____
14. Neurológico	_____	_____	_____

Los comentarios con respecto a conclusiones anormales - _____

La Recomendación Atlética de la Participación de los Licenciados Médicos Profesionales

REPLETO & ILIMITADA PARTICIPACION

LIMITO PARTICIPACION-NO puede tomar parte en el siguiente (verificó)

- Béisbol Baloncesto A campo través Fútbol americano Golf Fútbol
 Béisbol para chicas Natación Tenis pista(correr) Voleibol Lucha
 Lanzamiento

Espacio Libre pendiente documentado sigue de _____

No aprobado para la Participación Atlética debido a: _____

Nombre de Médico Licenció Profesional (Imprimió) _____

La Fecha _____

Firma de Médico Licenció Profesional _____

Numero del teléfono _____

El permiso y la liberación de los Padres o el Guardián (Firme después del examen físico se ha completado.)

Yo verifique la certeza de la información en el lado opuesto de esta forma y doy mi consentimiento para el estudiante denominado para entrar en actividades atléticas aprobados como un representante de su escuela, menos que esas actividades indicadas por encima del profesional licenciado. Doy también mi permiso para el médico del equipo, entrenador atlético, u otro personal calificado para dar los primeros auxilios el tratamiento a mi hijo o la hija en un acontecimiento atlético en caso de la herida.

El nombre del padre/guardián (Imprimió) _____

Firma del padre/guardián _____

Dirección de domicilio (Apartados de correos de calle, la ciudad, el estado, la cremallera) _____

El numero del teléfono _____

Esta forma se ha desarrollado con la ayuda del Comité en la Medicina de Deporte del Iowa la Sociedad Médica y ha sido aprobada para el uso por el Departamento de Iowa de la Educación, Iowa Educa Alto la Asociación Atlética, Chicas de Iowa Educan Alto Unión Atlética. Las escuelas son favorecidas a no cambiar esta forma de su formato publicado. Las formas adicionales de la escuela ciertamente pueden ser conectadas a esta forma.