MARYLAND PUBLIC SECONDARY SCHOOL ATHLETIC ASSOCIATION (MPSSAA)
Recommended Preparticipation Physical Form
MPSSAA Medical Advisory Committee

Student Athlete and Parent/Guardian Check list for Sports Registration

_____ 1. Please make sure to read all information that your school provides about Eligibility, Expectations, Tryouts, Practice & Game Schedules, Transportation (to and from games), Login to the School System Registration website.

_____ 2. Page 2: Health History form. This is filled out by the student athlete & parent/guardian. Please fill out the Student Athlete Heath History form, take it to the Pre-participation Physical Exam (PPE) appointment and review with the Healthcare Professional. Make sure to clarify/explain any questions that you have answered "YES". Please keep a copy to turn into the school.

_____3. Page 3: Pre-participation Physical Exam (PPE). This will be completed by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Certified Registered Nurse Practitioner (CRNP) or Physician Assistant – Certified (PA-C) only.
Pre-participation Physical may not be completed/signed by a parent/guardian even if they are a licensed healthcare professional.

- **Before leaving the appointment, please make sure the following have been completed:**
  - **___ The Healthcare provider signed, dated, and stamped the PPE.**
  - **___ The Healthcare provider has checked off the appropriate participation in athletics box.**
  - **___ You have both the Health History form and Pre-participation, Physical Exam (PPE) form. (you will need to provide both forms to the school during sports registration)**

_____ 4. Page 4: Emergency Information Form (to be completed and signed by parent/guardian). This information will be shared with the coach(es) in case of an emergency at practice/game.

_____ 5. Page 5: Maryland State Department of Education Office of Childcare Medication Administration Authorization Form. This form must be completed fully for Childcare Providers/staff to administer the required medication. This authorization is NOT TO EXCEED 1 YEAR. This form is required for both prescription and non-prescription/over the counter (OTC) medications. Prescription medication must be in a container labeled by the pharmacist or prescriber. Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.

Completion of the Preparticipation Physical is a requirement for student-athlete participation in interscholastic athletics. Falsifying information, forging signatures, or misrepresentation of a student's physical fitness compromises the health and safety of the student and may lead to penalties assessed by the local educational agency, including potential determination of ineligibility.

MARYLAND PUBLIC SECONDARY SCHOOL ATHLETIC ASSOCIATION (MPSSAA)

PART II- MEDICAL HISTORY (Explain "YES" answers below) Name: _____Grade: _____

This form must be completed and signed, prior to the physical examination, for review by examining practitioner. **Explain "YES" answers below with number of the question.** Circle questions you don't know the answers to.

GENERAL MEDICAL HISTORY	YES	NO
1. Do you have any concerns you want 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 conditions? If so, please identify: ☐ Asthma ☐Anemia ☐Diabetes ☐ Infections. ☐Other: _____	☐	☐
4. Are you taking any medications or supplements daily?	☐	☐
5. Do you have allergies to any medications?	☐	☐
6. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?	☐	☐
7. Have you ever spent the night in the hospital? If yes, why? _____	☐	☐
8. Have you ever had surgery?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
9. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
10. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
11. Does your heart race, flutter in your chest or skip beats (irregular beats) during exercise?	☐	☐
12. Has a doctor ever ordered a test for your heart? For example, electrocardiography or echocardiography.	☐	☐
13. Has a doctor ever told you that you have any heart problems, including: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki Disease ☐ Other _____	☐	☐
14. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
15. Have you ever had a seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
16. Does anyone in your family have a heart problem?	☐	☐
17. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning or unexplained car crash)?	☐	☐
18. 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)?	☐	☐
19. Has anyone in your family had a pacemaker or an implanted defibrillator before age 50?	☐	☐
BONE AND JOINT QUESTIONS	**YES**	**NO**
20. 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?	☐	☐
21. Do you currently have a bone, muscle, or joint injury that bothers you?	☐	☐
MEDICAL QUESTIONS	**YES**	**NO**
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
23. Do you have asthma or use asthma medicine (inhaler, nebulizer)?	☐	☐

MEDICAL QUESTIONS CONTINUED	YES	NO
24. Have you had mononucleosis (mono) within the last month?	☐	☐
25. Are you missing a kidney, eye, testicle, spleen or other internal organ?	☐	☐
26. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
27. Have you ever become ill while exercising in the heat?	☐	☐
28. When exercising in the heat, do you have severe muscle cramps?	☐	☐
29. Do you have headaches from exercise?	☐	☐
30. Have you ever had numbness, tingling or weakness in your arms or legs or been unable to move your arms or legs AFTER being hit or falling?	☐	☐
31. Do you have sickle cell trait or disease? Does someone in your family have sickle cell trait or disease?	☐ ☐	☐ ☐
32. Have you had any other blood disorders?	☐	☐
33. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?	☐	☐
34. Have you had or do you have any problems with your eyes or vision?	☐	☐
35. Do you wear glasses or contacts?	☐	☐
36. Do you wear protective eyewear like goggles or a face shield?	☐	☐
37. Do you worry about your weight?	☐	☐
38. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
39. Do you limit or carefully control what you eat?	☐	☐
40. Have you ever had an eating disorder?	☐	☐
41. Are you on a special diet or do you avoid certain types of foods or food groups?		
42. Allergies to food or stinging insects?	☐	☐
43. Have you ever had a COVID-19 diagnosis? Date:	☐	☐
44. What is the date of your last Tdap or Td (tetanus) immunization? (circle type) Date: _____		
FEMALES ONLY	**YES**	**NO**
45. Have you ever had a menstrual period?	☐	☐
46. Age when you had your first menstrual period: _____		
47. Number of periods in the last 12 months: _____		
48. When was your most recent menstrual period? _____		

EXPLAIN "YES" ANSWERS BELOW list the number you are clarifying/explaining

-
-
-
-
-
-
-

List medications and nutritional supplements you are currently taking here:

→ Parent/Guardian Signature: _____ Date: _____ → Athlete's Signature: _____

MARYLAND PUBLIC SECONDARY SCHOOL ATHLETIC ASSOCIATION (MPSSAA)

PART III- PHYSICAL EXAMINATION

(Pre-participation Physical may not be completed/signed by a parent/guardian even if a licensed healthcare professional)

NAME_____ **DATE OF BIRTH**_____ **SCHOOL**_____

Height		Weight		Sex Assigned at Birth	
BP /	RR	Resting pulse	Vision R 20/ L 20/	Corrected ☐ Yes ☐ No	
Pediatric Population > 13 years and older within normal limits =			**BP (F) 102-121/64-79 mmHg**	**BP (M) 102-124/64-80 mmHg**	
			RR 12-20 breaths per minute	**Pulse 55-90 bpm**	

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance (Marfan stigmata: kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse, and aortic insufficiency)		
Eyes/ears/nose/throat (Pupils equal, hearing)		
Neck - Lymph nodes, thyroid enlargement		
Heart (Murmurs: auscultation standing, supine, +/- Valsalva)		
Pulses (radial, femoral, pedal)		
Lungs		
Abdomen		
Skin (Herpes simplex virus, lesions suggestive of MRSA or tinea corporis)		
Neurologic (cranial nerve and gait)		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional (i.e. Double leg squat, single leg squat, box drop, or step drop test)		

Consider ECG, Echocardiogram, and referral to cardiology if abnormal cardiac history/exam or family history to address Sudden Cardiac Arrest & Sudden Cardiac Death risk.

Consider cognitive evaluation or baseline neuropsychiatric testing if history of significant prior to concussion.

Emergency medications required on-site: ☐ Inhaler ☐ Epinephrine ☐ Glucagon ☐ Other:

COMMENTS:

I have reviewed the data above, reviewed the student's medical history form and make the following commendations for the students' participation in athletics:

☐ **MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION**

☐ **MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATION FOR FURTHER EVALUATION OR TREATMENT OF:**

_____

☐ **MEDICALLY ELIGIBLE ONLY FOR THE FOLLOWING SPORTS:**_____

Reason:_____

☐ **NOT MEDICALLY ELIGIBLE FOR ANY SPORTS**

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Medical History.

→ **PRACTITIONER SIGNATURE:** _____ **(MD, DO, NP or PA) + DATE**:** _____

EXAMINER'S NAME AND DEGREE (PRINT): _____ PHONE NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Physician Office Stamp:

+Only signature of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted.

MARYLAND PUBLIC SECONDARY SCHOOL ATHLETIC ASSOCIATION (MPSSAA)

PART IV- EMERGENCY INFORMATION FORM* (To be completed and signed by the parent/guardian)

Please Print

STUDENT'S NAME: _____ GRADE: _____AGE: _____DOB: _____
SPORT(S): _____
Please list any significant health problems that might be significant to a physician evaluating your child **in case of an emergency:**

PLEASE LIST ANY ALLERGIES TO MEDICATIONS, ETC:

IS THE STUDENT CURRENTLY PRESCRIBED AN INHALER? (circle only one) YES NO
IS THE STUDENT CURRENTLY PRESCRIBED AN EPI PEN? (circle one one) YES NO

Primary Contact Name: _____Relationship to student: _____

DAYTIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

EVENING PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

CELL PHONE NUMBER: _____

Secondary Contact Name: _____Relationship to student: _____

DAYTIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

EVENING PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

CELL PHONE NUMBER: _____

→ I CERTIFY ALL OF THE ABOVE INFORMATION IS CORRECT: _____
Parent/Guardian signature

Date: _____ PARENT/GUARDAIN NAME (PLEASE PRINT) _____

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.

PARENT'S REQUEST TO ADMINISTER MEDICATION IN SCHOOL

Dear Parent/Legal Guardian:
To request medication administration at school, this form must be completed and signed by you and your child's medical provider.

- A new form is needed for all changes in medication, dose, or time.
- The medication should be brought to school by a parent/guardian or responsible adult.
- The medication container must be labeled by the pharmacy with the student's name, prescriber's name, name of medication, dosage, route, conditions for storage, prescription date, and expiration date.
- Unless otherwise specified, medication order is valid for the entire school year.
- **Expired and discontinued medication not picked up by the last day of school will be destroyed.**

HEALTH CARE PROVIDER'S INSTRUCTIONS FOR GIVING MEDICATION IN SCHOOL

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/Frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Special/Emergency Instructions: _____

Prescriber's Name/Title: _____ Phone: _____

Address: _____ Fax: _____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. (I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.) I/We authorize the school nurse to communicate with the health care provider.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone: _____

FOR ALTERED SCHOOL SCHEDULES, THE FOLLOWING MEDICATION GUIDELINES WILL APPLY UNLESS YOU INDICATE OTHERWISE IN WRITING:

- One-hour late opening: Doses will be given as usual, with minor modifications in timing, if needed.
- Two-hour late opening: Medications scheduled to be given before 10 a.m. will not be given in school; other doses will be given according to the prescribed schedule.
- Three-hour early dismissal: Medications scheduled to be given at lunchtime or later will not be given.

AUTHORIZATION FOR STUDENT TO CARRY EPINEPHRINE AUTO-INJECTOR AND/OR INHALER

Prescriber Authorization (Signature): _____ Date: _____

Parent/Guardian Authorization (Signature): _____ Date: _____

TO BE COMPLETED BY THE SCHOOL

Date form received at the school: _____ Received by: _____