



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 Health 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. Students who require medication at school (including during school team practices or games) must have a doctor's order on file with the school's nurse for each medicine. Please visit this link and take this form to your Healthcare provider for school medication administration authorization. (This needs to be completed each year) [School Medication Administration Authorization Form \(marylandpublicschools.org\)](https://marylandpublicschools.org/SchoolMedicationAdministrationAuthorizationForm)

The information provided on the Health History and Pre-Participation Physical is considered confidential medical records, it is established and maintained for every student. The confidentiality of a student's medical records information is protected under the federal Family Education Rights and Privacy Act (FERPA), Maryland state law and/or the local school system policy, as applicable.

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.

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:

☐ Healthcare Professional completed and reviewed a Mental Health Screening with the athlete.

☐ 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.

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)** _____

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