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. 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)

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.

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. Have you ever been diagnosed with an eating disorder?	☐	☐
39. Are you on a special diet or do you avoid certain types of foods or food groups?	☐	☐
40. Allergies to food or stinging insects?	☐	☐
41. Have you ever had a COVID-19 diagnosis? Date:		
42. 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:

☐ **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.

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.

MARYLAND STATE DEPARTMENT OF EDUCATION
EQUITY AND EXCELLENCE

MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

Maryland
DEPARTMENT OF HEALTH

This order is valid only for school year (current) _____ including the summer session.

School: _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

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: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ (Month / Day / Year) to _____ (Month / Day / Year)

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ FAX: _____

Address: _____

_____

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

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

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 as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

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

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____
Signature Date

School RN approval for self carry/self administration of emergency medication: _____
Signature Date

Order reviewed by the school RN: _____
Signature Date

2023