



NMAA PRE-PARTICIPATION EVALUATION (PPE) PACKET

*In accordance with New Mexico Activities Association Bylaw 6.15,
the following sports physical packet must be used for all pre-participation examinations.*

PURPOSE

The PPE is designed **to screen for injuries, illnesses, or other factors that increase an athlete's risk for injury or illness.** Experts in the field of athletic training, sports medicine, orthopaedics, family medicine, pediatrics, and osteopathics agree that the identification of predisposing factors that threaten one's safety are vital to participation in sport and will serve to improve the health and safety of athletes and active individuals.

The NMAA employs the use of the Preparticipation Physical Evaluation (PPE) Monograph, 5th Edition. The PPE Monograph was developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine. It is also endorsed by the National Athletic Trainers' Association and the National Federation of State High School Associations. The NMAA Sports Medicine Advisory Committee also endorses the use of the 5th PPE Monograph.

NMAA PPE REQUIRED FORMS

	Completed
✓ Emergency Information (parent/guardian)	<input type="checkbox"/>
✓ *Medical History (parent/guardian)	<input type="checkbox"/>
✓ *Physical Examination (HCP)	<input type="checkbox"/>
✓ Medical Eligibility (HCP)	<input type="checkbox"/>
✓ Consent to Treat (parent/guardian)	<input type="checkbox"/>
✓ Concussion Awareness (parent/guardian/student)	<input type="checkbox"/>

****Medical History and Physical Examination forms should remain with the parent/guardian and/or health care provider, unless parent/guardian provides written authorization to release the forms to the school.***

FOR PARENTS

- ✓ The **Medical History** form should be filled out jointly with your son or daughter prior to the appointment.
- ✓ Please pay special attention to the "**Heart Health Questions**" listed on the **Medical History** form.
- ✓ The **Medical History** and **Physical Examination** forms should remain with you and/or your health care provider unless written authorization is provided to release this information to the school.
- ✓ Return all other forms to the school. No forms need to be returned to the New Mexico Activities Association.

FOR SCHOOLS

- ✓ Schools should collect **Emergency Information, Medical Eligibility, Consent to Treat, and Concussion Awareness** forms.
- ✓ The **Medical History** and **Physical Examination** forms should NOT be collected unless written authorization is received from the parent/guardian.

NOTES FOR APPROVED HCP

- ✓ Healthcare providers should review **Medical History** prior to evaluation and **retain a copy in the medical file.**
- ✓ Healthcare providers should complete and sign the **Physical Examination** and **Medical Eligibility** forms.
- ✓ **Medical Eligibility** form should be returned to the parent/guardian to submit to the school.
- ✓ **Medical History** and **Physical Examination** forms should be returned to the parent/guardian to secure.
- ✓ **American Academy of Pediatrics Cardiac Screening Guidance:**
 - Primary care providers should be aware of features of the clinical history, family history and physical examination suggestive of a risk for SCA/SCD.
 - A thorough history, family history and physical examination are necessary to begin assessing for SCA/SCD risk.
 - The ECG should be the first test ordered when there is concern for SCA risk. It should be interpreted by a medical provider trained in recognizing electrical heart disease.
 - Survivors of SCA and family members of those with SCA or SCD should have a thorough evaluation to assess for a potential genetic etiology.



EMERGENCY INFORMATION

(Parent/Guardian, please fill out prior to examination)

STUDENT INFORMATION

NAME (Last, First, MI): _____ AGE: ____ GRADE: ____ DATE OF BIRTH: __/__/__

EMAIL ADDRESS: _____ CELL PHONE: _____

HOME ADDRESS: _____
Street City State Zip

PARENT/GUARDIAN INFORMATION #1

NAME (Last, First): _____

PRIMARY PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

HOME ADDRESS: _____
Street City State Zip

PARENT/GUARDIAN INFORMATION #2 (if applicable)

NAME (Last, First): _____

PRIMARY PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

HOME ADDRESS: _____
Street City State Zip

EMERGENCY CONTACT

NAME (Last, First): _____

PRIMARY PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

HOME ADDRESS: _____
Street City State Zip

PARTICIPANT INSURANCE (Participants must be covered by accident/injury insurance prior to participation)

Insurance Carrier	Policy Number	Group ID
-------------------	---------------	----------

SPORTS PARTICIPATING (Check all that apply)

Fall	Winter	Spring	Other
<input type="checkbox"/> Cross Country	<input type="checkbox"/> Basketball	<input type="checkbox"/> Baseball	<input type="checkbox"/> Bowling
<input type="checkbox"/> Football	<input type="checkbox"/> Cheer	<input type="checkbox"/> Golf	<input type="checkbox"/>
<input type="checkbox"/> Soccer	<input type="checkbox"/> Dance	<input type="checkbox"/> Softball	<input type="checkbox"/>
<input type="checkbox"/> Volleyball	<input type="checkbox"/> Powerlifting	<input type="checkbox"/> Tennis	<input type="checkbox"/>
	<input type="checkbox"/> Swimming/Diving	<input type="checkbox"/> Track/Field	
	<input type="checkbox"/> Wrestling		

PARENT/GUARDIAN VERIFICATION (Print, Sign & Date)

Print Name _____ Sign Name _____

Date _____

A copy of this form should be placed into the athlete's medical file and should not be shared with schools or sports organizations without written authorization from parent/guardian.

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

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

Have you had COVID-19? (check one): Y N

Have you been immunized for COVID-19? (check one): Y N If yes, have you had: One shot Two shots
 Three shots Booster date(s) _____

List past and current medical conditions. _____

Have you ever had 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 (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (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 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	Unsure	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 polymorphic 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, 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 <i>Staphylococcus aureus</i> (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, had tingling, had 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?	Unsure		
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 foods or food groups?				
28. Have you ever had an eating disorder?				
MENSTRUAL QUESTIONS		N/A	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: _____

This form should be returned to the parent to secure and should not be shared with schools or sports organizations without written authorization from parent/guardian.

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- 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, e-cigarettes, chewing tobacco, snuff, or dip?
 - During the past 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 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, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> 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 ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis 		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 		

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

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization. History and Physical Examination forms should not be shared with schools or sports organizations without written authorization from parent/guardian.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

- Medically eligible for all 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 on this form. A copy of the physical examination findings are 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 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 or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____

