****PARENT OR GUARDIAN, PLEASE COMPLETE AND SIGN THIS FORM PRIOR TO APPOINTMENT****

PRE-PARTICIPATION PHYSICAL EVALUATION (PPE)

MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____

Age: _____ Sex: _____ Grade in School: _____

List any past or present medical conditions:

_____

List any past surgical procedures:

_____

List all current medications, including over-the-counter medications and supplements:

_____

_____

List any allergies (medications, insects, foods) including severity of reaction and if an EpiPen has been prescribed:

_____

_____

STUDENT MENTAL HEALTH QUESTIONNAIRE

Over the last 2 weeks, has your student been bothered by any of the following? **Please circle a response for each category.**

	Not at all	Several days	Over half of 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 HEALTH QUESTIONS **(Explain any "YES" answers at end of form)**	**YES**	**NO**
1. Do you have any concerns that you would like to discuss with your provider today?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any pertinent medical issues at this time? Have you recently been ill?		
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 pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter, or skip beats during exercise?		
7. Has a doctor ever told you that you have a heart problem or high blood pressure?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (EKG) or echocardiography (Echo).		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	**YES**	**NO**
9. Do you get light-headed or feel excessive shortness of breath during exercise?		
10. Have you ever had a seizure?		
HEART QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
11. Has any family member or relative died of a heart problem or of an unexpected or unexplained sudden death **before the age of 35 yrs**, including a drowning or accident?		
12. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT or short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
13. Has anyone in your family had a pacemaker or defibrillator **before the age of 35 yrs**?		

BONE AND JOINT QUESTIONS	YES	NO
14. Have you ever had a broken bone (fracture), or an injury to a bone, muscle, ligament, tendon, or joint that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, tendon, or joint injury that bothers you?		
MEDICAL QUESTIONS	**YES**	**NO**
16. Do you have asthma? Do you wheeze, cough, or get short of breath with exercise?		
17. Are you missing a kidney, your spleen, a testicle (males), or any other organs?		
18. Do you have a hernia or a bulge, mass, or pain in your groin or testes (males)?		
19. Do you have any present or recurring skin rashes or infections such as methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, prolonged headaches, memory problems, or personality changes?		
21. Have you ever had numbness, tingling, or weakness in your arms or legs or been unable to move your arms or legs?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does anyone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision or your ears or hearing? Glasses or contacts?		

MEDICAL QUESTIONS (CONTINUED)	YES	NO
25. Do you worry about your weight?		
26. Are you trying to gain or lose weight, or has anyone ever recommended that you try to 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?		
FEMALES ONLY	**YES**	**NO**
29. Have you ever had a menstrual period?		
30. If so, how old were you when you had your first menstrual period?		
31. When was your last menstrual period (LMP)?		
32. Other:		

****PLEASE EXPLAIN ANY "YES" ANSWERS HERE****

I hereby state, to the best of my knowledge, that the information and answers to the questions on this form are complete and accurate. I further grant permission for my student to be evaluated and examined by a health care professional and understand that this pre-participation physical evaluation involves a limited examination and is not intended to nor will it prevent injury or sudden death. I also understand that if the examination is provided without expectation of payment, there shall be no cause of action pursuant to Louisiana R.S. 9:2798 against the volunteer health care professionals and/or their employers under Louisiana law. I further give permission for my student's completed pre-participation physical evaluation forms (medical history, physical examination, and medical eligibility forms) to be released to the school's head of school, administrative staff, athletic director, and/or applicable coaching staff.

Signature of Parent or Legal Guardian: _____

Printed Name of Parent or Legal Guardian: _____

Phone Number of Parent or Legal Guardian: _____

Date: _____