OSSAA PHYSICAL FORM (UPDATED APRIL 2026)

Last Name:_____ First Name:_____ Age:____ Date of Birth:____/____/20___

Grade (2026-2027):_____ Student ID#_____ Sex:_____ Activity:_____ Date of Exam: ____/____/20___

PHYSICAL EXAMINATION

Height: Weight: BP: / Pulse: Vision: R 20/ 20/ Corrected: Y N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions of methicillin-resistant Staphylococcus aureus (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 • Double-leg squat test, single leg squat test, and box drop or step drop test		

_____**Medically eligible for all activity without restriction**

_____**Medically eligible for all activity with recommendations for further evaluation or treatment of:**_____

_____**Medically eligible for certain activity:**_____

_____**Not medically eligible pending further evaluation for:**_____

_____**Not medically eligible for any activity**

Recommendations:_____

_____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The individual does not have apparent clinical contraindications to practice and can practice in the sports(s) as outlined on this form. 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 provider (print or type): _____ **Date:** ____/____/_____

Address: _____ **Phone:** _____

Signature of health care professional: _____

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Grade (2026-2027):_____ Student ID#:_____ Sex:_____ Activity:_____ Date of Exam: ____/____/20____

List any past and current medical conditions (asthma, diabetes, anemia, etc.). _____

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 (i.e., 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 or no interest 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 of 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?		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART 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 a game?			

BONE AND JOINT QUESTIONS (cont.)	YES	NO
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 Staphylococcus aureus (MRSA)?		
20. Have you had a concussion or a 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 able 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 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?		
25. Do you worry about your weight?		
26. Are you trying to or has someone 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:

_____

_____

_____

_____

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a results of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student. I (we) hereby state, to the best of my (our) knowledge, my (our) answers to above questions are complete and correct.

Signature of athlete: _____ Date: ____/____/_____

Signature of parent or guardian: _____ Date: / /

OSSAA PHYSICAL FORM (UPDATED APRIL 2026)

PHYSICAL EVALUATION FORM AND PARENTAL CONSENT

No student shall be eligible to represent his/her school in athletics or marching band until there is on file with the school a physical examination and parental consent certificate.

All physicals for OSSAA participation must be given no earlier than May 1 of the preceding year in which the students are to participate and before the first day of practice in that student's particular activity. The physical will be valid from the date of the physical given until the next required physical. Parent(s) or guardian(s) must sign the parental consent form each year before the student participates in any organized athletic practice session including contest participation.

The pre-participation evaluation form is designed to identify risk factors prior to participation by way of a thorough medical history and physical examination. A qualified physician, physician's assistant, or an advanced practice nurse covered by professional liability insurance shall give the physical examinations.

1. The most current version of the OSSAA PPE form should be used; any other form used must contain a minimum of the information requested on the OSSAA PPE form.
2. The PPE Form must be signed and completed in its entirety. No pre-signed or pre-stamped forms will be accepted.
3. SIGNATURES
   - ❑ The person administering the PPE's signature must be hand-written and dated. No signature stamps will be accepted.
   - ❑ The parent/guardian signatures must be hand-written and dated.
   - ❑ The student-athlete signature must be hand-written and dated.

PARENT/GUARDIAN CONSENT FORM

(To be retained by member school with history and parent consent forms)

STUDENT NAME: _____

DATE OF BIRTH: _____

SCHOOL: _____

The above information is correct to the best of my knowledge. I hereby give my informed consent for the above-mentioned student to participate in activities. I understand the risk of injury with participation. If my son/daughter becomes ill or is injured, necessary medical care can be instituted by physicians, coaches, athletic trainers or other personnel properly trained. I further acknowledge and consent that, as a condition for participating in activities, identifying information about the above-mentioned student may be disclosed to OSSAA in connection with any investigation or inquiry concerning the student's eligibility to participate in/or any possible violation of OSSAA rules. OSSAA will undertake reasonable measure to maintain the confidentiality of such identifying information, provided that such information has not otherwise been publicly disclosed in some manner.

SIGNATURE OF PARENT/ GUARDIAN _____ DATE _____

SIGNATURE OF STUDENT _____ DATE _____

FOR EDUCATIONAL AND INFORMATIONAL PURPOSES
(NOT REQUIRED FOR FULFILLMENT OF PHYSICAL FORM)

YOUR PARTNER IN
Protecting Your Child's Heart



My HeartCheck

PREVENTATIVE
Youth Heart Screenings

WHY have your child tested?

Every year, more than 40,000 children are born with a heart defect. While some are found at birth, many go undetected. Even more concerning, certain conditions don't appear until later in childhood or adolescence—when they can lead to sudden cardiac arrest without warning.

That's why early detection is critical.

My HeartCheck was developed with guidance from the Mayo Clinic and Johns Hopkins to identify hidden heart conditions before they become serious. In fact, our screening program is one of the most advanced and accessible options available today.

Based in the Kansas City area, we proudly serve families across **Kansas, Missouri, Iowa, Nebraska, Oklahoma, Texas, and Colorado**. We've screened over 18,000 kids—and that number continues to grow.

Ultimately, if there's a way to prevent tragedy, wouldn't you want to take it?

Don't wait. Schedule your child's HeartCheck today. MyHeartCheck.org