Board of Directors Meeting – Agenda Item

Date of BOD Meeting: 2/9/23 **Submitted by:** (●) FHSAA Staff ( ) BOD ( ) Committee ( ) Ind.

For which Committee: [ ] Finance [ ] Governance [ ] Operations [ ] Appeals

Item is for: [✓] Action [ ] Discussion [ ] Information only

For General Business Meeting Item is: [✓] Action [ ] Discussion [ ] Information only

Data Source: FHSAA Bylaw 9.7; 9.7.3 **(i.e. FHSAA Bylaw/Policy, Fla. Statute, etc.)**

Topic:

A Pre-Participation Examination (PPE) is required by Florida Statute 1002.20(17)(b), 1006.20(2)(c) and FHSAA Bylaw 9.7 to ensure safe participation in sports by student-athletes.

Specifically: Submission of the full EL2 to member schools. This request is to adopt the updated FHSAA EL2 form (four total pages) recommended by the SMAC with the exception of removing questions 30-33. Furthermore, only the fourth page of the EL2 (the medical eligibility form) will be submitted to the member school. The qualified health care practitioner performing the examination or parent/guardian will keep the medical history and/or examination forms (pages 1-3).

Detailed Information (brief statement--background, observations, data, etc.):

The submission of the full FHSAA EL2 Form to member schools has created concerns and questions from parents, school district administrators, school board members, and coaches regarding the health privacy of student-athletes. While the Association understands it is vital to protect the privacy of all student-athletes, we must address the important role medical history plays in a pre-participation physical examination. Therefore, this recommendation provides pertinent medical history to the qualified health care practitioner and gives schools the medical authorization necessary for allowing athletic participation, while protecting the privacy of the student-athlete.

Provide attachment(s) as applicable

Executive Director Recommendation:

The Executive Director endorses adopting the updated EL2 form (as amended above in the topic section) and requiring only the fourth page (Medical Eligibility) to be collected by the member school. Pages 1-3 of the EL2 will remain with the qualified health care practitioner performing the examination or parent/guardian of the student-athlete.

Rationale & Impact:

The intent of this proposal is to provide an updated PPE form which protects a student-athlete's privacy while including pertinent medical information a health care provider at a member school would need access to.

Alternative to Recommendation:

Printed Name of Individual/Committee Submitting Item — *Signature*

Craig Damon

Printed Name of FHSAA Staff Member Presenting Item — *Signature*

PAGES TO BE KEPT BY

QUALIFIED HEALTH CARE PRACTITIONER

OR

PARENT/GUARDIAN

FLORIDA HIGH SCHOOL ATHLETIC ASSOCIATION

EL2

Revised 6/23

PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

HISTORY FORM

Student Information (to be completed by student and parent) print legibly

Student's full name: _____ Sex assigned at birth: _____ Age: ____ Date of birth: _____ / _____ / _____

School: _____ Grade in school: _____ Sport(s): _____

Home address: _____ City: _____ Home phone: (___) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to contact in case of emergency: _____ Relationship to student: _____

Emergency contact cell phone: (___) _____ Work phone: (___) _____ Other phone: (___) _____

Family healthcare provider: _____ City/State: _____ Office phone: (___) _____

List past and current medical conditions:

_____

Have you ever had surgery? If yes, please list all surgical procedures and dates:

_____

Medicines and supplements: Please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional)

_____

Do you have any allergies? If yes, please list all of your allergies (ie. medicines, pollens, food, insects)

_____

Patient Health Questionnaire version 4 (PHQ-4)

Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)

	Not at all	Several days	Over half of the days	Nearly everyday
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

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 illnesses?		
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?		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No
8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
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		Yes	No
11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (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?		

This form is not considered valid unless all sections are complete

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

Student-athlete name: _____ **Date of birth:** ____/____/_____ **School:** _____

BONE AND JOINT QUESTIONS		Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle ligament, or joint injury that currently bothers you?		
MEDICAL QUESTIONS		**Yes**	**No**
17	Do you cough, wheeze or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
18	Are you missing a kidney, an eye, a testicle, your spleen or any other organ?		
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?		
21	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?		
23	Have you ever become ill while exercising in the heat?		
24	Do you or does someone in your family have sickle cell trait or disease?		
25	Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (continued)		Yes	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that your gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

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Participation in high school sports is not without risk. The student athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. Florida Statute §1006.20, requires a student candidate for an interscholastic athletic team to successfully complete a preparticipation evaluation as the first step of injury prevention. This preparticipation medical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by §1006.20, Florida Statutes, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO) and/or cardio stress test. The FHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your health care provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student Athlete Name: _____ (Printed) Student Athlete Signature: _____ Date: ____/____/_____

Parent/Guardian Name: _____ (Printed) Parent/Guardian Signature: _____ Date: ____/____/_____

Parent/Guardian Name: _____ (Printed) Parent/Guardian Signature: _____ Date: ____/____/_____

EL2

Revised 6/23

This evaluation form should be retained by the healthcare provider and/or parent.
This assessment is valid for 365 calendar days from the date signed below.

Physical Examination Form:

Student-athlete name: _____ **Date of birth** ____/____/_____ **School:** _____

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?	• 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?	

☐ Verify completion of FHSAA EL2 Medical History form pages 1 and 2, review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include (Q4–Q13 of History Form). (check box, if complete)

EXAMINATION		
Height:	Weight:	
BP: / (/) Pulse:	Vision: R 20/ L 20/	Corrected: ☐ Y ☐ N
MEDICAL – healthcare professional shall initial each assessment	**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[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL – healthcare professional shall initial each assessment	**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		

This form is not considered valid unless all sections are complete

[a] Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. *The FHSAA Sports Medicine Advisory Committee (SMAC) strongly recommends to a student athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.*

Name of healthcare professional (print or type): _____ Date of exam: ____/____/_____

Address: _____ Phone: _____ Email: _____

Signature of healthcare professional: _____ Credentials: _____ License #: _____

PAGE

SUBMITTED TO SCHOOL

EL2

Revised 6/23

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This completed form shall be kept on file by the school. This form is valid for 365 calendar days from the dated signature below.

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student or parent) *print legibly*

Student's name: _____ Sex assigned at Birth:_____ Age:_____ Date of birth: _____ / ___ / _____

School: _____ Grade in school: _____ Sport(s): _____

Home address: _____ City: _____ Home phone: (_____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to contact in case of emergency:_____ Relationship to student: _____

Emergency contact cell phone: (____) _____ Work phone: (____) _____ Other phone: (____) _____

Family healthcare provider: _____ City/State: _____ Office phone: (____) _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Recommendations: (use additional sheet, if necessary)

_____

I hereby certify that I have examined the above-named student-athlete using the FHSAA EL2 Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed and treated by an appropriate health care professional prior to participation in activities.

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

Address: _____ Phone: _____

Signature of healthcare professional:_____ Credentials:_____ License #: _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

☐ Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp *(if required by school)*

Medications: *(use additional sheet, if necessary)*

List: _____

_____

Relevant medical history to be reviewed by athletic trainer/team physician: *explain below, add additional sheets if necessary*

☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical history ☐ Sickle cell trait ☐ Other

Explain: _____

_____

Signature of student: _____ Date: ___/___/___ Signature of Parent/Guardian: _____ Date: ___/___/___

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct. We understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO) and/or cardio stress test.

This form is not considered valid unless all sections are complete

PAGE

SUBMITTED TO SCHOOL

IF APPLICABLE

FLORIDA HIGH SCHOOL ATHLETIC ASSOCIATION

EL2

Revised 6/23

PREPARTICIPATION PHYSICAL EVALUATION (Supplement)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This completed form shall be kept on file by the school. This form is valid for 365 calendar days from the dated signature below.

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

MEDICAL ELIGIBILITY FORM - Referred Provider Form

Student Information (to be completed by student or parent) print legibly

Student's full name: _____ Sex assigned at birth: _____ Age: ____ Date of birth: _____ / _____ / ____

School: _____ Grade in school: _____ Sport(s) _____

Home address: _____ City: _____ Home phone: (_____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to contact in case of emergency: _____ Relationship to student: _____

Emergency contact cell phone: (____) _____ Work phone: (____) _____ Other phone: (____) _____

Family healthcare provider: _____ City/State: _____ Office phone: (____) _____

Referred for: _____ Diagnosis: _____

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

☐ Medically eligible for all sports without restriction as of the date signed below

☐ Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports participation

Further Recommendations: **(use additional sheet, if necessary)**

_____

Name of healthcare professional (print or type): _____ Date: ____/____/_____

Address: _____ Phone: _____

Signature of healthcare professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*