PPE Guide for Athletic Directors and Coaches

In conjunction with the Office of School Health, the PSAL has released a new pre-Participation Physical Exam form (PPE). The form will encourage thorough exams while also protecting student privacy.

New Procedures for PPEs

New Form

Students using the new form must:

1. Take the entire packet to their medical provider for completion
    a. Page 1: Health History Form (Will remain on file with the medical provider and will not be returned to the school)
    b. Page 2: Physical Examination Form (Will remain on file with the medical provider and will not be returned to the school)
    c. Page 3: Recommendations for Participation in Physical Education & Sports Form
2. Submit "Recommendations for Participation in Physical Education & Sports" form to the Athletic Director or coach

Auditing Procedure

For every student, you must have one of the following:

1. Active "Recommendations for Participation in Physical Education & Sports" form

Audit Requirements for New Form

For the audit, the "Recommendations for Participation in Physical Education & Sports" form must have the following to pass the audit:

1. Student first and last names
2. Student OSIS number
3. Student Grade
4. Student Campus/School
5. Clearance for sport where the student is listed on the roster (i.e., "No Contact Sports," "No Limited Contact Sports," and/or "No Non-Contact Sports" have <u>NOT</u> been checked)
6. Medical Provider Name
7. Medical Provider Title (Must be MD, DO, PA, or NP)
8. Medical Provider Address (can be written or part of stamp)
9. Medical Provider Phone (can be written or part of stamp)
10. License/NPI (can be written or part of the stamp)
11. Medical Provider Signature
12. Date
13. Medical Provider Stamp

General Notes:

1. The Accommodations/Protective Equipment section and the allergies section both have a space for "None." If these sections do not denote accommodations or allergies and the "none" option is not checked, the form is still considered compliant.
2. There are sections in the form to write in restrictions and recommendations. Restrictions are directives that **MUST** be followed. Recommendations are directives that should be followed but will not affect a students' clearance if they do not complete them.
3. If a form denotes a duration for "Not cleared" or "Not cleared pending further evaluation": the student will not be able to participate until they return a new "Recommendations for Participation in Physical Education & Sport" form indicating clearance for their chosen sport. This applies even if the duration listed on the form has passed.
4. If a form denotes a duration for "Cleared with Restrictions/Adaptations/Accommodations": The student must return a new form by their medical provider for when the restriction, adaptation, or accommodation is lifted. If the student continues to participate with the restriction/adaptation/accommodation, no new form is needed.
5. If there is an error on the form, the form must be taken back to the medical provider in order to be amended. The Athletic Director or coach **should not alter the form** in any way, even if they have personally contacted the medical provider. The exceptions to this rule are:
    a. Student OSIS
    b. Student Grade
    c. Student Campus/School
    d. License/NPI Number

6. If the "Health History" form (page 1) and/or the "Physical Examination" form (page 2) are given to the school, coach, or athletic director, these forms must be returned to the parent/guardian and must not be placed in the student's file.

Preferred Name

If a student's preferred name (name on the roster) does not match the name on the PPE form, write a note indicating the student's name as it appears on the roster and the student's legal name or name as appears on the form. Sign and date the note and include it in the student's file.

Amended Forms

When a form must be amended, the medical provider may:

- Submit a brand new form;
- Make the amendment and then place an additional medical provider stamp next to the amendment; or
- Submit an additional note that has been signed and stamped by the medical provider with an explanation of the amendment (this note must be attached to the original PPE form)

Electronic Records

Copies of the "Recommendations for Participation in Physical Education & Sports" form that have been emailed or faxed directly from a medical provider's office will be accepted. Amendment notes that have been signed and stamped will also be accepted by email or fax. A copy of the email or fax cover sheet should remain attached to the record in the student's file.

Sample #1: Sammy Soe. Sammy is a senior on Dewitt Clinton's Volleyball Team. Findings: All demographic information is listed on the form. Since the form indicates "Cleared for All Sports Without Restriction" Sammy is cleared for volleyball. Doctor demographic information is complete and the form is stamped.

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION & SPORTS

To be completed by student's health care provider or school medical provider

Last Name	First Name	OSIS#	Grade
Soe	Sammy	123456	12

School/Campus/ATSDBN: Dewitt Clinton Campus

- [x] **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION**
- [ ] **NOT CLEARED** **Duration:** _____
- [ ] **NOT CLEARED PENDING FURTHER EVALUATION** **Duration:** _____
- [ ] **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:** _____
- [ ] **CLEARED WITH RESTRICTIONS/ADAPTATIONS/ACCOMMODATIONS** **Duration:** _____

- [ ] **NO CONTACT SPORTS:** includes basketball, competitive cheerleading, diving, field hockey, football (tackle), gymnastics, ice hockey, lacrosse, rugby, soccer, stunt, wrestling
- [ ] **NO LIMITED CONTACT SPORTS:** includes baseball, cross-country skiing, fencing, flag football, handball, high jump, ice skating, pole vault, skiing, softball, volleyball
- [ ] **NO NON-CONTACT SPORTS:** includes archery, badminton, bowling, cricket, discus, double dutch, golf, javelin, race walking, rifle, shot-put, swimming, table tennis, tennis, track & field

- [ ] **OTHER RESTRICTIONS** _____

ACCOMMODATIONS/PROTECTIVE EQUIPMENT

- [x] None
- [ ] Athletic Cup
- [ ] Sports/Safety Goggles
- [ ] Medical/Prosthetic Device
- [ ] Pacemaker
- [ ] Insulin Pump/Insulin Sensor
- [ ] Brace/Orthotic
- [ ] Hearing Aides
- [ ] Protective Ear Gear
- [ ] Other _____

- [ ] **PERTINENT MEDICAL HISTORY** _____
- [ ] **ALLERGIES** _____ [x] None

MEDICATIONS

- [ ] Has prescribed pre-exercise medication _____
- [ ] Has prescribed PRN medication _____
- [ ] Student is Self-Carry/Self-Administer, **unless in an emergency or student is incapable of self-administration**

Explanation _____

- [ ] **OTHER RECOMMENDATIONS** _____

I have examined the above named student and completed the pre-participation physical examination. The athlete may/may not participate in the sport(s) as outlined above. A copy of the physical exam will be provided to the school medical room staff and can be made available to the school administration at the request of the parents. This form may be rescinded: by a medical provider if there are any changes in the student's health that could affect his/her safe participation in sports, and/or until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)	Title	License/NPI
Sample Provider	NP	123456

Address	Medical Provider's Stamp
123 Sample St	*Must Have Stamp*

Phone	Fax	Email*
999-999-9999	999-999-9999	sample@md.com

Signature of medical provider	Date
[signature]	08/01/2019

NYC_ED_PSAL_Sports_Clearance_Form_02112019

This PPE would be ruled COMPLIANT during a PSAL audit

Sample #2: Jane is a senior athlete on Grand Street Campus' soccer team. Findings: All necessary demographic information is present on the form. The form indicates "Cleared for All Sports Without Restriction With Recommendations for Further Evaluation or Treatment For:" and indicates rehabilitation for an ankle sprain. Because the rehabilitiation is a recommendation and not a requirement, Jane is cleared to participate in soccer. The doctor demographic information is complete and the form is stamped.

Last Name	First Name	OSIS#	Grade
Doe	Jane	123456	12

School/Campus/ATSDBN: Grand Street Campus

- ☐ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION**
- ☐ **NOT CLEARED** **Duration:** _____
- ☐ **NOT CLEARED PENDING FURTHER EVALUATION** **Duration:** _____
- ☒ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:** Ankle Sprain → additional rehabilitation visits for strengthening.
- ☐ **CLEARED WITH RESTRICTIONS/ADAPTATIONS/ACCOMMODATIONS** **Duration:** _____

- ☐ **NO CONTACT SPORTS:** includes basketball, competitive cheerleading, diving, field hockey, football (tackle), gymnastics, ice hockey, lacrosse, rugby, soccer, stunt, wrestling
- ☐ **NO LIMITED CONTACT SPORTS:** includes baseball, cross-country skiing, fencing, flag football, handball, high jump, ice skating, pole vault, skiing, softball, volleyball
- ☐ **NO NON-CONTACT SPORTS:** includes archery, badminton, bowling, cricket, discus, double dutch, golf, javelin, race walking, rifle, shot-put, swimming, table tennis, tennis, track & field

- ☐ **OTHER RESTRICTIONS** _____

ACCOMMODATIONS/PROTECTIVE EQUIPMENT

☒ None ☐ Athletic Cup ☐ Sports/Safety Goggles ☐ Medical/Prosthetic Device ☐ Pacemaker ☐ Insulin Pump/Insulin Sensor
☐ Brace/Orthotic ☐ Hearing Aides ☐ Protective Ear Gear ☐ Other _____

- ☐ **PERTINENT MEDICAL HISTORY** _____
- ☐ **ALLERGIES** _____ ☒ None

MEDICATIONS

- ☐ Has prescribed pre-exercise medication _____
- ☐ Has prescribed PRN medication _____
- ☐ Student is Self-Carry/Self-Administer, **unless in an emergency or student is incapable of self-administration**

Explanation _____

- ☐ **OTHER RECOMMENDATIONS** _____

I have examined the above named student and completed the pre-participation physical examination. The athlete may/may not participate in the sport(s) as outlined above. A copy of the physical exam will be provided to the school medical room staff and can be made available to the school administration at the request of the parents. This form may be rescinded: by a medical provider if there are any changes in the student's health that could affect his/her safe participation in sports, and/or until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)	Title	License/NPI
Sample Provider	MD	123456

Address	Medical Provider's Stamp
123 Sample St	*Must Have Stamp*

Phone	Fax	Email
999-999-9999	999-999-9999	sample@md.com

Signature of medical provider	Date
[signature]	08/01/2019

NYC_ED_PSAL_Sports_Clearance_Form_02112019

This PPE would be ruled COMPLIANT during a PSAL audit.

Sample #3: John is a freshman wrestler on the Port Richmond wrestling team. Findings: All necessary demographic information is present on the form. John has been restricted from contact sports. Wrestling is listed under the contact sports distinction. Physician demographic information is complete and the form is stamped.

Last Name	First Name	OSIS#	Grade
Johnson	John	123456	9

School/Campus/ATSDBN: Port Richmond High School

- ☐ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION**
- ☐ **NOT CLEARED** **Duration:** _____
- ☐ **NOT CLEARED PENDING FURTHER EVALUATION** **Duration:** _____
- ☐ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:** _____
- ☒ **CLEARED WITH RESTRICTIONS/ADAPTATIONS/ACCOMMODATIONS** **Duration:** _____

☒ **NO CONTACT SPORTS:** includes basketball, competitive cheerleading, diving, field hockey, football (tackle), gymnastics, ice hockey, lacrosse, rugby, soccer, stunt, wrestling

☐ **NO LIMITED CONTACT SPORTS:** includes baseball, cross-country skiing, fencing, flag football, handball, high jump, ice skating, pole vault, skiing, softball, volleyball

☐ **NO NON-CONTACT SPORTS:** includes archery, badminton, bowling, cricket, discus, double dutch, golf, javelin, race walking, rifle, shot-put, swimming, table tennis, tennis, track & field

- ☐ **OTHER RESTRICTIONS** _____

ACCOMMODATIONS/PROTECTIVE EQUIPMENT

☐ None ☐ Athletic Cup ☐ Sports/Safety Goggles ☐ Medical/Prosthetic Device ☐ Pacemaker ☐ Insulin Pump/Insulin Sensor
☒ Brace/Orthotic ☐ Hearing Aides ☐ Protective Ear Gear ☐ Other _____

- ☒ **PERTINENT MEDICAL HISTORY** (R) ACL tear 2018, Asthma, 2 prior Concussions
- ☒ **ALLERGIES** Tree Nuts ☐ None

MEDICATIONS

- ☐ Has prescribed pre-exercise medication _____
- ☒ Has prescribed PRN medication Albuterol Inhaler
- ☒ Student is Self-Carry/Self-Administer, **unless in an emergency or student is incapable of self-administration**

Explanation Student has Epi-Pen for Tree nut allergy. Must carry in his bag at all times. School staff should know where it is located.

- ☐ **OTHER RECOMMENDATIONS** _____

I have examined the above named student and completed the pre-participation physical examination. The athlete may/may not participate in the sport(s) as outlined above. A copy of the physical exam will be provided to the school medical room staff and can be made available to the school administration at the request of the parents. This form may be rescinded: by a medical provider if there are any changes in the student's health that could affect his/her safe participation in sports, and/or until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)	Title	License/NPI
Sample Provider	DO	123456

Address	Medical Provider's Stamp
123 Sample St	*Must Have Stamp*

Phone	Fax	Email
999-999-9999	999-999-9999	Sample@md.com

Signature of medical provider	Date
Shayla Nearly	08/01/2019

NYC_ED_PSAL_Sports_Clearance_Form_02112019

This PPE would be ruled NOT COMPLIANT during a PSAL audit. Since John has been restricted from contact sports, he cannot participate in wrestling. If John was participating in a limited or no contact sport, this form would be in compliance.

John is a sophomore cross country athlete from Bryant. He suffered 2 concussions last year while playing basketball and rugby. His physician has referred him to a neurologist and set up a follow up appointment for 8/15/2019 after he receives his neurology results.

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION & SPORTS

To be completed by student's health care provider or school medical provider

Last Name	First Name	OSIS#	Grade
DOE	John	1234567	10

School/Campus/ATSDBN: Lehman Campus

- ☐ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION**
- ☐ **NOT CLEARED** **Duration:** _____
- ☒ **NOT CLEARED PENDING FURTHER EVALUATION** **Duration:** 8/15/19
- ☐ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:** _____
- ☐ **CLEARED WITH RESTRICTIONS/ADAPTATIONS/ACCOMMODATIONS** **Duration:** _____

☐ **NO CONTACT SPORTS:** includes basketball, competitive cheerleading, diving, field hockey, football (tackle), gymnastics, ice hockey, lacrosse, rugby, soccer, stunt, wrestling

☐ **NO LIMITED CONTACT SPORTS:** includes baseball, cross-country skiing, fencing, flag football, handball, high jump, ice skating, pole vault, skiing, softball, volleyball

☐ **NO NON-CONTACT SPORTS:** includes archery, badminton, bowling, cricket, discus, double dutch, golf, javelin, race walking, rifle, shot-put, swimming, table tennis, tennis, track & field

☐ **OTHER RESTRICTIONS** _____

ACCOMMODATIONS/PROTECTIVE EQUIPMENT

☐ None ☐ Athletic Cup ☐ Sports/Safety Goggles ☐ Medical/Prosthetic Device ☐ Pacemaker ☐ Insulin Pump/Insulin Sensor
☐ Brace/Orthotic ☐ Hearing Aides ☐ Protective Ear Gear ☐ Other _____

☒ **PERTINENT MEDICAL HISTORY** 2 diagnosed concussions in 2018

☐ **ALLERGIES** _____ ☐ None

MEDICATIONS

☐ Has prescribed pre-exercise medication _____

☐ Has prescribed PRN medication _____

☐ Student is Self-Carry/Self-Administer, **unless in an emergency or student is incapable of self-administration**

Explanation _____

☐ **OTHER RECOMMENDATIONS** _____

I have examined the above named student and completed the pre-participation physical examination. The athlete may/may not participate in the sport(s) as outlined above. A copy of the physical exam will be provided to the school medical room staff and can be made available to the school administration at the request of the parents. This form may be rescinded: by a medical provider if there are any changes in the student's health that could affect his/her safe participation in sports, and/or until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)	Title	License/NPI
Sample Provider	NP	123456

Address	Medical Provider's Stamp
123 Sample St	* Must have Stamp *

Phone	Fax	Email
999-999-9999	999-999-9999	

Signature of medical provider	Date
	08/01/19

This PPE would be ruled NOT COMPLIANT during a PSAL audit. Even though today's date is after 8/15, the duration on the does not indicate when the student is cleared. John will need to submit a new clearance page with his new clearance decision after returning from his visit with the doctor.

Sample #5: Mary Major is a junior on Seward Park Campus' tennis team. Findings: Mary's form indicates that she is "Cleared with Restrictions/Adaptations/Accommodations." However, no restriction, adaptation, or accommodation has been provided on the form.

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION & SPORTS

To be completed by student's health care provider or school medical provider

Last Name	First Name	OSIS#	Grade
Major	Mary	123456	11

School/Campus/ATSDBN: Seward Park Campus

- ☐ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION**
- ☐ **NOT CLEARED** **Duration:** _____
- ☐ **NOT CLEARED PENDING FURTHER EVALUATION** **Duration:** _____
- ☐ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:** _____
- ☒ **CLEARED WITH RESTRICTIONS/ADAPTATIONS/ACCOMMODATIONS** **Duration:** _____

- ☐ **NO CONTACT SPORTS:** includes basketball, competitive cheerleading, diving, field hockey, football (tackle), gymnastics, ice hockey, lacrosse, rugby, soccer, stunt, wrestling
- ☐ **NO LIMITED CONTACT SPORTS:** includes baseball, cross-country skiing, fencing, flag football, handball, high jump, ice skating, pole vault, skiing, softball, volleyball
- ☐ **NO NON-CONTACT SPORTS:** includes archery, badminton, bowling, cricket, discus, double dutch, golf, javelin, race walking, rifle, shot-put, swimming, table tennis, tennis, track & field

- ☐ **OTHER RESTRICTIONS** _____

ACCOMMODATIONS/PROTECTIVE EQUIPMENT

☐ None ☐ Athletic Cup ☐ Sports/Safety Goggles ☐ Medical/Prosthetic Device ☐ Pacemaker ☐ Insulin Pump/Insulin Sensor
☐ Brace/Orthotic ☐ Hearing Aides ☐ Protective Ear Gear ☐ Other _____

- ☐ **PERTINENT MEDICAL HISTORY** _____
- ☐ **ALLERGIES** _____ ☐ None

MEDICATIONS

- ☐ Has prescribed pre-exercise medication _____
- ☐ Has prescribed PRN medication _____
- ☐ Student is Self-Carry/Self-Administer, **unless in an emergency or student is incapable of self-administration**

Explanation _____

- ☐ **OTHER RECOMMENDATIONS** _____

I have examined the above named student and completed the pre-participation physical examination. The athlete may/may not participate in the sport(s) as outlined above. A copy of the physical exam will be provided to the school medical room staff and can be made available to the school administration at the request of the parents. This form may be rescinded: by a medical provider if there are any changes in the student's health that could affect his/her safe participation in sports, and/or until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)	Title	License/NPI
Sample Provider	DO	123456

Address	Medical Provider's Stamp
123 Sample St	* Must Have Stamp *

Phone	Fax	Email
999-999-9999	999-999-9999	sample@md.com

Signature of medical provider	Date
[signature]	08/01/2019

This form would be ruled NOT COMPLIANT during a PSAL audit. Mary must return her form to the physician to document the restriction, adaptation, or accommodation that is needed in order for her to participate.