

PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION

INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first four Sections of the CIPPE Form. Upon completion of Sections 1, 2, and 3 by the parent/guardian, and Section 4 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be performed earlier than June 1st and shall be effective, regardless of when performed during a school year, until the next May 31st.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 5 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will then determine whether Section 6 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student's Name _____ Male/Female (circle one)

Date of Student's Birth: ____/____/____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Current Physical Address _____

Current Home Phone # () _____ Parent/Guardian Current Cellular Phone # () _____

Fall Sport(s): _____ Winter Sport(s): _____ Spring Sport(s): _____

EMERGENCY INFORMATION

Parent's/Guardian's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Telephone # () _____

Family Physician's Name _____, MD or DO (circle one)

Address _____ Telephone # () _____

Student's Allergies _____

Student's Health Condition(s) of Which an Emergency Physician Should be Aware _____

Student's Prescription Medications _____

SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

The student's parent/guardian must complete all parts of this form.

A. I hereby give my consent for _____ born on _____ who turned _____ on his/her last birthday, a student of _____ School and a resident of the _____ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____ - 20____ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

| Sport | Signature of Parent or Guardian |
|--------------------------|---------------------------------|
| Baseball (Spring) | |
| Basketball (Winter) | |
| Bowling (Winter) | |
| Cross Country (Fall) | |
| Field Hockey (Fall) | |
| Football (Fall) | |
| Golf (Fall) | |
| Gymnastics (Winter) | |
| Lacrosse (Spring) | |
| Rifle (Winter) | |
| Soccer (Fall) | |
| Soccer-Girls (Spring) | |
| Softball (Spring) | |
| Swimming & Diving | |
| Tennis-Girls (Fall) | |
| Tennis-Boys (Spring) | |
| Track-Indoor (Winter) | |
| Track & Field (Spring) | |
| Volleyball-Girls (Fall) | |
| Volleyball-Boys (Spring) | |
| Water Polo (Fall) | |
| Wrestling (Winter) | |
| Other | |

B. Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent's/Guardian's Signature _____ Date ____ / ____ / ____

C. Disclosure of records needed to determine eligibility: To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

Parent's/Guardian's Signature _____ Date ____ / ____ / ____

D. Permission to use name, likeness, and athletic information: I consent to PIAA's use of the herein named student's name, likeness, and athletically related information in reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent's/Guardian's Signature _____ Date ____ / ____ / ____

E. Permission to administer emergency medical care: I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care.

Parent's/Guardian's Signature _____ Date ____ / ____ / ____

SECTION 3: HEALTH HISTORY

**Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.**

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| 1. Has a doctor ever denied or restricted your participation in sport(s) for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like asthma or diabetes)? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Has a doctor ever told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply): | | | 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur | | | 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection | | | 32. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> | 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | 34. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 36. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | 37. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or Contest? If yes, circle affected area below: | <input type="checkbox"/> | <input type="checkbox"/> | 40. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 41. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 42. Are you unhappy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest | | | 43. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes | | | 44. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> | 45. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> | 46. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | FEMALES ONLY | | |
| | | | 47. Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 48. How old were you when you had your first menstrual period? | | _____ |
| | | | 49. How many periods have you had in the last 12 months? | | _____ |
| | | | 50. Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

| No(s). | Explain "Yes" answers here: |
|--------|-----------------------------|
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| | |
| | |

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date ____/____/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date ____/____/____

**SECTION 4: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION
AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER**

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name _____ Age _____ Grade _____

Enrolled in _____ School Sport(s) _____

Height _____ Weight _____ % Body Fat (optional) _____ BP _____ / _____ (_____ / _____ , _____ / _____) RP _____

If either the blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended. **Age 10-12:** BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96

Vision R 20/____ L 20/____ Corrected YES NO (circle one) Pupils: Equal____ Unequal____

| MEDICAL | NORMAL | ABNORMAL FINDINGS |
|----------------------------|--------|-------------------|
| Appearance | | |
| Eyes/Ears/Nose/Throat | | |
| Hearing | | |
| Lymph Nodes | | |
| Cardiovascular | | |
| Cardiopulmonary | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only) | | |
| Neurological | | |
| Skin | | |

| MUSCULOSKELETAL | NORMAL | ABNORMAL FINDINGS |
|--------------------|--------|-------------------|
| Neck | | |
| Back | | |
| Shoulder/Arm | | |
| Elbow/Forearm | | |
| Wrist/Hand/Fingers | | |
| Hip/Thigh | | |
| Knee | | |
| Leg/Ankle | | |
| Foot/Toes | | |

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

CLEARED **CLEARED**, with recommendation(s) for further evaluation or treatment for: _____

NOT CLEARED for the following types of sports (please check those that apply):

COLLISION CONTACT NON-CONTACT STRENUOUS MODERATELY STRENUOUS NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type) _____ License # _____

Address _____ Phone () _____

AME's Signature _____ MD, DO, PAC, CRNP, or SNP (circle one) Date of CIPPE ____/____/____

SECTION 5: RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal, or the Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY.

If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the herein named student shall submit a completed Section 6, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

SUPPLEMENTAL HEALTH HISTORY

Student's Name _____ Male/Female (circle one)

Date of Student's Birth: ____/____/____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Winter Sport(s): _____ Spring Sport(s): _____

CHANGES TO PERSONAL INFORMATION (In the spaces below, identify any changes to the Personal Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Current Home Address _____

Current Home Telephone # () _____ Parent/Guardian Current Cellular Phone # () _____

CHANGES TO EMERGENCY INFORMATION (In the spaces below, identify any changes to the Emergency Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Parent's/Guardian's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Telephone # () _____

Family Physician's Name _____, MD or DO (circle one)

Address _____ Telephone # () _____

SUPPLEMENTAL HEALTH HISTORY:

Explain "Yes" answers at the bottom of this form. Circle questions you don't know the answers to.

- | | Yes | No | | Yes | No |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Since completion of the CIPPE, have you sustained an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? | <input type="checkbox"/> | <input type="checkbox"/> | 3. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? | <input type="checkbox"/> | <input type="checkbox"/> | 4. Since completion of the CIPPE, are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 5. Do you have any concerns that you would like to discuss with a physician? | <input type="checkbox"/> | <input type="checkbox"/> |

| No(s). | Explain "Yes" answers here: |
|--------|-----------------------------|
| | |
| | |
| | |

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date ____/____/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date ____/____/____