
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 the student's first sport in a 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, 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 shall be performed no 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, of the student's school will then determine whether Section 6 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student Name _____ Age _____ Grade _____

Current Address _____

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

EMERGENCY INFORMATION

Primary Emergency Contact Person's Name _____ Relationship _____

Current Home Phone # (_____) _____ Work # (_____) _____ Cell # (_____) _____

Secondary Emergency Contact Person's Name _____ Relationship _____

Current Home Phone # (_____) _____ Work # (_____) _____ Cell # (_____) _____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Phone # (_____) _____

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

Address _____ Phone # (_____) _____

Student Allergies _____

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

Student's Prescription Medications (Inhalers, Insulin, etc.):

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 ____/____/____

(please turn page over)

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)	
Cheerleading (Fall)	
Cheerleading (Winter)	
Cross Country (Fall)	
Field Hockey (Fall)	
Football (Fall)	
Golf (Fall)	
Boys Lacrosse (Spring)	
Girls Lacrosse (Spring)	
Soccer (Fall)	
Soccer-Girls (Spring)	
Softball (Spring)	
Swimming & Diving	
Tennis-Girls (Fall)	
Tennis-Boys (Spring)	
Track & Field (Spring)	
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 ____/____/____

Students Name _____ Age _____ Grade _____

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"/>	23. Has your doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>																		
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<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"/>																		
3. Are you currently taking any prescription or nonprescription (over-the counter) medicines or pills or using an inhaler?(List them below)	<input type="checkbox"/>	<input type="checkbox"/>	25. Does anyone in your family have asthma?	<input type="checkbox"/>	<input type="checkbox"/>																		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>																		
5. Have you ever passed out or nearly passed out DURING 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"/>																		
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<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"/>	29. Do you have any current skin problems (rashes, pressure sores, itching, acne, warts, fungus, blisters, etc)?	<input type="checkbox"/>	<input type="checkbox"/>																		
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>																		
9. Has a doctor ever told you that you have (check all that apply)	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>																		
<input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart murmur			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>																		
<input type="checkbox"/> High/low blood sugar <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Heart infection			33. Have you ever had a seizure?	<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"/>	34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>																		
11. Has anyone in your family died for no apparent reason?	<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"/>																		
12. Does anyone in your family have a heart problem?	<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"/>																		
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<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"/>																		
14. Do you or anyone in your family have Marfan syndrome (MFS)?	<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"/>																		
15. Have you ever spent the night in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>																		
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>																		
17. Have you ever had an injury, like a sprain, strain, muscle or ligament tear, or tendonitis, which caused you to miss a practice or contest? If yes, circle the affected area 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"/>																		
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below.	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you unhappy with your weight?	<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"/>	43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>																		
<table border="0" style="width: 100%; font-size: small;"> <tr> <td>Ankle</td> <td>Knee</td> <td>Hand/Fingers</td> <td>Head/Neck</td> <td>Foot/Toes</td> <td>Elbow</td> </tr> <tr> <td>Hip</td> <td>Wrist</td> <td>Upper Back</td> <td>Lower Back</td> <td>Shin/Calf</td> <td>Chest</td> </tr> <tr> <td>Thigh</td> <td>Forearm</td> <td>Upper Arm</td> <td>Shoulder</td> <td>Upper Arm</td> <td></td> </tr> </table>	Ankle	Knee	Hand/Fingers	Head/Neck	Foot/Toes	Elbow	Hip	Wrist	Upper Back	Lower Back	Shin/Calf	Chest	Thigh	Forearm	Upper Arm	Shoulder	Upper Arm				44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
Ankle	Knee	Hand/Fingers	Head/Neck	Foot/Toes	Elbow																		
Hip	Wrist	Upper Back	Lower Back	Shin/Calf	Chest																		
Thigh	Forearm	Upper Arm	Shoulder	Upper Arm																			
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"/>																		
22. Do you regularly use a brace or assistive device?	<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 (use additional paper if necessary)

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

Student Signature _____ Date ____/____/____

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

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

Section 4: PIAA COMPREHENSIVE INITIAL P_{RE}-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

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

Student's Name _____ Age _____ Grade _____

Enrolled in _____ School Sport(s) _____

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

Vision R 20/ _____ L 20/ _____ Corrected Yes No (circle one) Pupils: Equal _____ Unequal _____

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

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) _____

Authorized Medical Examiner's Name (print/type) _____ License # _____

Address _____ Phone () _____

Authorized Medical Examiner's Signature _____ MD, DO, PAC, CRNP or SNP (circle one) Date ____/____/____