

# PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION

Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school, the student is required to complete a physical evaluation. A student completing a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE) need not have a re-certification for a period of twelve (12) months, unless the student suffers a serious illness or injury within those twelve (12) months.

Students seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests through the CIPPE must have the appropriate person(s) complete the first four Sections of this form (Sections 5 and 6 should be completed only if a re-certification becomes necessary). Upon completion of Sections 1 and 2 by the parent/guardian, and Section 4 by a licensed physician of medicine or osteopathic medicine, those Sections must be turned in to the student's school for retention by the school. Upon completion, Section 3 may be retained by the student and/or the student's physician.

## SECTION 1: PERSONAL AND EMERGENCY INFORMATION

### PERSONAL INFORMATION

Student's Name \_\_\_\_\_

Current Physical Address \_\_\_\_\_  
\_\_\_\_\_

Current Home Telephone # (            ) \_\_\_\_\_ Current Cellular Telephone # (            ) \_\_\_\_\_

### EMERGENCY INFORMATION

Emergency Contact Person's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ 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 \_\_\_\_\_

Student's Immunizations (e.g. tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis, pneumococcal; meningococcal; varicella):

Up to date (see attached documentation)

Not up to date Specify \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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-Girls (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)	

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 or Scrimmages and Contests involving PIAA member schools. Such requirements 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 or Scrimmages and 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 a licensed physician of medicine or osteopathic medicine 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 or Scrimmages and 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 assume and agree to pay indebtedness or physicians' and surgeons' fees and hospital charges 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 sports 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 happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>																
	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 8.3%;">Head</td> <td style="width: 8.3%;">Neck</td> <td style="width: 8.3%;">Shoulder</td> <td style="width: 8.3%;">Upper arm</td> <td style="width: 8.3%;">Elbow</td> <td style="width: 8.3%;">Forearm</td> <td style="width: 8.3%;">Hand/Fingers</td> <td style="width: 8.3%;">Chest</td> </tr> <tr> <td>Upper back</td> <td>Lower back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/shin</td> <td>Ankle</td> <td>Foot/Toes</td> </tr> </table>	Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/Fingers	Chest	Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/Toes			43.	Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/Fingers	Chest																
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/Toes																
20.	Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	44.	Has anyone recommended you change your weight or eating habits?	<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"/>	45.	Do you limit or carefully control what you eat?	<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"/>																
				<b>FEMALES ONLY</b>																			
				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:

**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 PHYSICIAN

Must be completed and signed by the licensed physician of medicine or osteopathic medicine performing the herein named student's comprehensive initial pre-participation physical evaluation.

Student's Name \_\_\_\_\_ Age \_\_\_\_\_

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\_\_\_\_

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 and further certify that the student does not have any communicable illness or condition, which would pose a danger to teammates and/or competitors:

**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) \_\_\_\_\_

Physician's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone (     ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ MD or DO (circle one) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION 5: PIAA RE-CERTIFICATION BY PARENT/GUARDIAN**

This form must be completed by the parent/guardian of any student who (1) previously participated in PIAA interscholastic athletic competition, pursuant to a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) subsequent to completion of the CIPPE (a) suffered an illness or injury which rendered the student unable to participate in 25% or more of the Regular Season Contests in the immediately preceding sports season and/or (b) suffered an illness or injury which resulted in absence from school for ten (10) or more days, or which required surgery.

**SUPPLEMENTAL HEALTH HISTORY**

(Attach Section 3: HEALTH HISTORY from CIPPE to this form)

Student's Name \_\_\_\_\_ Age \_\_\_\_\_

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 Physical Address \_\_\_\_\_

Current Home Telephone # ( ) \_\_\_\_\_ Current Cellular Telephone # ( ) \_\_\_\_\_

**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):**

Emergency Contact Person's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ 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 \_\_\_\_\_

Student's Immunizations (e.g. tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis, pneumococcal; meningococcal; varicella)  Up to date (see attached documentation)  Not up to date Specify \_\_\_\_\_

**SUPPLEMENTAL HEALTH HISTORY:** Describe those illnesses and injuries suffered by the student since completion of the CIPPE:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 6: PIAA COMPREHENSIVE PRE-PARTICIPATION PHYSICAL RE-EVALUATION AND RE-CERTIFICATION BY PHYSICIAN

Must be completed and signed by the licensed physician of medicine or osteopathic medicine performing the herein named student's comprehensive pre-participation physical re-evaluation.

Student's Name \_\_\_\_\_ Age \_\_\_\_\_

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\_\_\_\_

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 SUPPLEMENTAL HEALTH HISTORY, performed a comprehensive pre-participation physical re-evaluation of the herein named student, and, on the basis of such re-evaluation and the student's SUPPLEMENTAL 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 and further certify that the student does not have any communicable illness or condition, which would pose a danger to teammates and/or competitors:

**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) \_\_\_\_\_

Physician's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone (     ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ MD or DO (circle one) Date \_\_\_\_/\_\_\_\_/\_\_\_\_