Student’s Name

Age

Grade

Yes

**SECTION6: HEALTH HISTORY**

**Explain “Yes” answers at the bottom of this form.**

**Circle questions you don’t know the answers to.**

Yes

No

No

1.

2.

3.

Has a doctor ever denied or restricted your

participation in sport(s) for any reason?

Do you have an ongoing medical condition

(like asthma or diabetes)?

Are you currently taking any prescription or

nonprescription(over-the-counter) medicines

or pills?

23.

24.

25.

26.

27.

Has a doctor ever told you that you have

asthma or allergies?

Do you cough, wheeze, or have difficulty

breathing DURING or AFTER exercise?

Is there anyone in your family who has

asthma?

Have you ever used an inhaler or taken

asthma medicine?

Were you born without or are your missing

a kidney, an eye, a testicle, or any other

organ?

❑ ❑

❑ ❑

❑ ❑

❑ ❑

❑ ❑

❑ ❑

❑ ❑

4.

5.

6.

7.

8.

9.

Do you have allergies to medicines,

pollens, foods, or stinging insects?

Have you ever passed out or nearly

passed out DURING exercise?

Have you ever passed out or nearly

passed out AFTER exercise?

Have you ever had discomfort, pain, or

pressure in your chest during exercise?

Does your heart race or skip beats during

exercise?

❑ ❑

❑ ❑

❑ ❑

❑ ❑

❑ ❑

❑ ❑

28.

29.

30.

Have you had infectious mononucleosis

(mono) within the last month?

Do you have any rashes, pressure sores,

or other skin problems?

Have you ever had a herpes skin

infection?

❑ ❑

❑ ❑

❑ ❑

Has a doctor ever told you that you have

(check all that apply):

**CONCUSSION OR TRAUMATIC BRAIN INJ URY**

31.

Have you ever had a concussion (i.e. bell

rung, ding, head rush) or traumatic brain

injury?

Have you been hit in the head and been

confused or lost your memory?

Do you experience dizziness and/or

headaches with exercise?

❑ ❑

❑ ❑

❑ ❑

❑High blood pressure ❑Heart murmur

❑High cholesterol❑Heart infection

10.

11.

12.

13.

32.

33.

Has a doctor ever ordered a test for your

heart? (for example ECG, echocardiogram)

Has anyone in your family died for no

apparent reason?

Does anyone in your family have a heart

problem?

Has any family member or relative been

disabled from heart disease or died of heart

problems or sudden death before age 50?

Does anyone in your family have Marfan

Syndrome?

Have you ever spent the night in a

hospital?

❑ ❑

❑ ❑

❑ ❑

❑ ❑

❑ ❑

34.

35.

Have you ever had a seizure?

Have you ever had numbness, tingling, or

weakness in your arms or legs after being hit

or falling?

Have you ever been unable to move your

arms or legs after being hit or falling?

When exercising in the heat, do you have

severe muscle cramps or become ill?

Has a doctor told you that you or someone

in your family has sickle cell trait or sickle cell

disease?

Have you had any problems with your

eyes or vision?

Do you wear glasses or contact lenses? ❑ ❑

Do you wear protective eyewear, such as

goggles ora face shield?

❑ ❑

❑ ❑

36.

37.

38.

❑ ❑

❑ ❑

14.

15.

❑ ❑

❑ ❑

❑ ❑

16.

17.

Have you ever had surgery?

Have you ever had an injury, like a sprain,

muscle, or ligament tear, or tendonitis, which

caused you to miss a Practice or Contest?

If yes, circle affected area below:

Have you had any broken or fractured

bones or dislocated joints? If yes, circle

below:

Have you had a bone or joint injury that

required x-rays, MR I, CT, surgery, injections,

rehabilitation, physical therapy, a brace, a

cast, or crutches? If yes, circle below:

39.

❑ ❑

❑ ❑

❑ ❑

❑ ❑

40.

41.

18.

19.

❑ ❑

❑ ❑

42.

43.

44.

Are you unhappy with your weight?

Are you trying to gain or lose weight? ❑ ❑

Has anyone recommended you change

your weight or eating habits?

Do you limit or carefully control what you ❑ ❑

eat?

❑ ❑

Head

Neck

Shoulder

Upper

arm

Elbow

Forearm

Hand/

Chest

45.

46.

Fingers

Ankle

Upper

back

20.

Lower

back

Hip

Thigh

Knee

Calf/shin

Foot/

Toes

Do you have any concerns that you would

like to discuss with a doctor?

❑ ❑

❑ ❑

Have you ever had a stress fracture? ❑ ❑

Have you been told that you have or have

you had an x-ray for atlantoaxial (neck)

instability?

Do you regularly use a brace or assistive

device?

**FEMALES ONLY**

21.

❑ ❑

❑ ❑

47.

48.

Have you ever had a menstrual period? ❑ ❑

How old were you when you had your first

menstrual period?

How many periods have you had in the

last 12 months?

Are you pregnant?

22.

49.

50.

❑ ❑

**#’s**

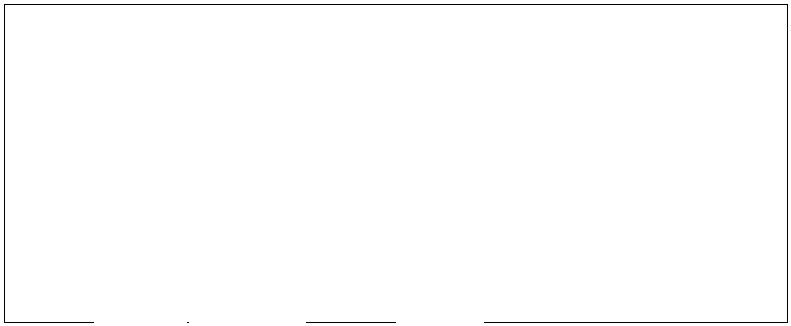
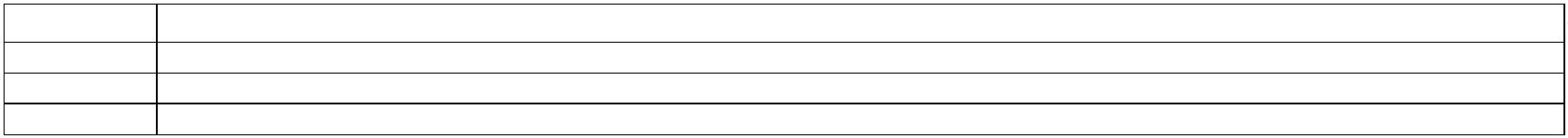
**Explain “Yes” answers here:**

**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\_\_\_\_/\_\_\_\_/\_\_\_\_\_

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**SECTION7: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATIONPHYSICAL EVALUATION**

**AND CERTIFICATIONOF AUTHORIZED MEDICAL EXA MINER**

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) \_\_\_\_\_\_ Brachial Artery BP\_\_\_\_\_/\_\_\_\_\_ (\_\_\_\_\_/\_\_\_\_\_ , \_\_\_\_\_/\_\_\_\_\_) RP\_\_\_\_\_\_\_

If either the brachial artery blood pres s ure (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/\_\_\_\_\_

**MEDICA L**

Corrected: YES NO (circle one)

**NORMA L**

Pupils: Equal\_\_ \_ \_ \_ Unequal\_ \_ \_ \_ \_

**ABNORMAL FINDINGS**

Appearance

Eyes/Ears/Nose/Throat

Hearing

Lymph Nodes

❑Heart murmur❑Femoral pulses to exclude aortic coarctation

❑Physical stigmata of Marfan syndrome

Cardiovascular

Cardiopulmonary

Lungs

Abdomen

Genitourinary (males only)

Neurological

Skin

**MUSCULOSKELETAL**

Neck

**NORMA** L

**ABNORMAL FINDINGS**

Back

Shoulder/Arm

Elbow/Forearm

Wrist/Hand/Fingers

Hip/Thigh

Knee

Leg/Ankle

Foot/Toes

I hereby certify that I have reviewed the HEALTHHISTORY, 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)

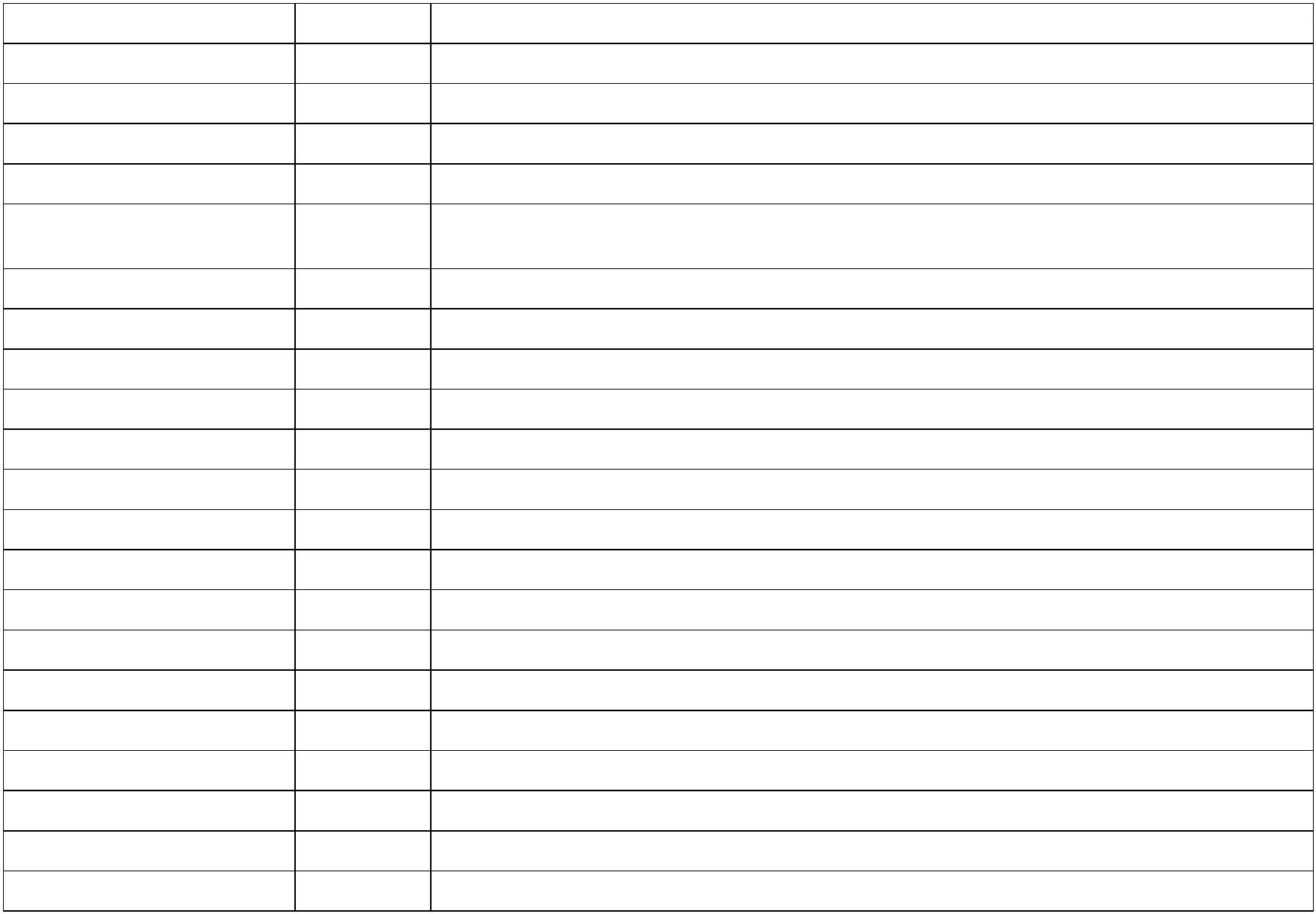
AME’s Name (print/type)

License #

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

)

AME’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD, DO, PAC, CRNP, or SNP (circle one) Certification Date of CIPPE \_\_\_/\_\_\_\_/\_\_\_

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