

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's Name _____ Age _____ Grade _____

Current Physical Address _____

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

EMERGENCY INFORMATION

Primary Emergency Contact Person'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 4: PIAA COMPREHENSIVE INITIAL PRE-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, of 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 _____

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 ____ / ____ / ____