IMPORTANT

Upload all pages of the completed physical/re-certification using the QR code shown here.

(Google/SCASD sign-in required to upload.)

Name: _____ DOB: _____ Grade: _____ Male Female (circle one)

Sport:_____**RUGBY**_____ School Attending: _____

MEDICAL HISTORY:

Athletes and Parents: This history is a critical element in the determination of an athlete's risk of injury in sports. Please take the time to read and answer all questions. **Please share this with the physician during the athlete's physical examination.**

	Yes	No		Yes	No
Any significant past injuries			Hospitalizations or surgeries		
Allergies, asthma, or wheezing			Seizures		
Dizziness or passing out			Head injuries or concussions		
Currently on medication(s)			Bone or joint injuries		
Chronic illness			Current on all vaccinations		

Allergies Other:

Comments/Explanations relating to above answers:_____

_____

_____

_____

_____

PHYSICAL EXAM - TO BE COMPLETED BY A PHYSICIAN

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____ Male Female (circle one)

Vision: R_____/_____ L _____/_____ Glasses/Contacts: Y N

Normal Abnormal Findings	Initials
Eyes	
Ears, Nose, Throat	
Mouth & Teeth	
Neck	
Cardiovascular	
Chest & Lungs	
Abdomen	
Skin Genitalia-Hernia (male)	
Musculoskeletal: ROM, strength, etc - neck	
Musculoskeletal: ROM, strength, etc - spine Musculoskeletal: ROM, strength, etc - shoulders Musculoskeletal: ROM, strength, etc - arms/hands Musculoskeletal: ROM, strength, etc - hips	
Musculoskeletal: ROM, strength, etc - thighs	
Musculoskeletal: ROM, strength, etc - knees Musculoskeletal: ROM, strength, etc - ankles	
Musculoskeletal: ROM, strength, etc - feet	
Neuromuscular	

Cleared to Participate:_____ Cleared After: _____Not Cleared:_____

Printed name of provider	Signature of examiner	Office phone	Date of examination

RE-CERTIFICATION BY PARENT/GUARDIAN

If you have already submitted a PIAA Physical Examination form to the SCASD Athletic Department for this school year, please complete this re-certification form in its place. **However, if any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the herein named student shall submit a new Physical Examination Form.**

SUPPLEMENTAL HEALTH HISTORY

Explain “Yes” answers at the bottom of this form. Circle questions you don’t know the answers to.

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? Yes No	4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	Yes	No
2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? Yes No	5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills?	Yes	No
3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? Yes No	6. Do you have any concerns that you would like to discuss with a physician?	Yes	No

#	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____/____/_____