

**SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION  
AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER**

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 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.

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             |        | <input type="checkbox"/> Heart murmur <input type="checkbox"/> Femoral pulses to exclude aortic coarctation<br><input type="checkbox"/> Physical stigmata of Marfan syndrome |
| 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) \_\_\_\_\_

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

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

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

**SECTION 7: RE-CERTIFICATION BY PARENT/GUARDIAN**

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal, or the Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY.

If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the herein named student shall submit a completed Section 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

**SUPPLEMENTAL HEALTH HISTORY**

Student's Name \_\_\_\_\_ Male/Female (circle one)

Student's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Student's Age on Last Birthday: \_\_\_\_ Grade \_\_\_\_ for 20\_\_ - 20\_\_ School Year

Winter Sport(s): \_\_\_\_\_ Spring 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 Home Address \_\_\_\_\_

Current Home Telephone # ( ) \_\_\_\_\_ Parent/Guardian Current Cellular Phone # ( ) \_\_\_\_\_

**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):**

Parent's/Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Parent/Guardian E-mail Address: \_\_\_\_\_

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 # ( ) \_\_\_\_\_

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

**Explain "Yes" answers at the bottom of this form. Circle questions you don't know the answers to.**

- |   |  |
|---|--|
| <p>1. Since completion of the CIPPE, have you sustained a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>                              |
| <p>2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  | <p>4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <div style="border: 1px solid black; padding: 2px; width: fit-content;"> <p>An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below</p> </div>                                    | <p>5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
|   | <p>6. Do you have any concerns that you would like to discuss with a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |

| #s | Explain yes answers; include injury, type of treatment & the name of the medical professional seen by student |
|----|---|
|    |   |
|    |   |
|    |   |
|    |   |

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