

SECTION 5: 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 sport(s) for any reason?	☐	☐	23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
2. Do you have an ongoing medical condition (like asthma or diabetes)?	☐	☐	24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐	25. Is there anyone in your family who has asthma?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐	26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐	28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐	30. Have you ever had a herpes skin infection?	☐	☐
9. Has a doctor ever told you that you have (check all that apply):			CONCUSSION OR TRAUMATIC BRAIN INJURY 31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? ☐ ☐ 32. Have you been hit in the head and been confused or lost your memory? ☐ ☐ 33. Do you experience dizziness and/or headaches with exercise? ☐ ☐ 34. Have you ever had a seizure? ☐ ☐ 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ☐ ☐ 36. Have you ever been unable to move your arms or legs after being hit or falling? ☐ ☐ 37. When exercising in the heat, do you have severe muscle cramps or become ill? ☐ ☐ 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ☐ ☐ 39. Have you had any problems with your eyes or vision? ☐ ☐ 40. Do you wear glasses or contact lenses? ☐ ☐ 41. Do you wear protective eyewear, such as goggles or a face shield? ☐ ☐ 42. Are you unhappy with your weight? ☐ ☐ 43. Are you trying to gain or lose weight? ☐ ☐ 44. Has anyone recommended you change your weight or eating habits? ☐ ☐ 45. Do you limit or carefully control what you eat? ☐ ☐ 46. Do you have any concerns that you would like to discuss with a doctor? ☐ ☐		
☐ High blood pressure ☐ Heart murmur	☐	☐			
☐ High cholesterol ☐ Heart infection					
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	☐	☐	47. Have you ever had a menstrual period?	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐	48. How old were you when you had your first menstrual period?	_____	
12. Does anyone in your family have a heart problem?	☐	☐	49. How many periods have you had in the last 12 months?	_____	
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	☐	☐	50. When was your last menstrual period?	_____	
14. Does anyone in your family have Marfan Syndrome?	☐	☐			
15. Have you ever spent the night in a hospital?	☐	☐			
16. Have you ever had surgery?	☐	☐			
17. 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: 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: 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:					
Head	Neck	Shoulder	Upper arm	Elbow	Forearm
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin
Hand/Fingers	Ankle	Foot/Toes			
20. Have you ever had a stress fracture?	☐	☐			
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐			
22. Do you regularly use a brace or assistive device?	☐	☐			

#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 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 _____ for 20____ - 20____
School Year

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		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ 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 ____/____/____