



**2020-2021**

**SPORTS PIAA PHYSICAL PACKET**

**\*\*\* COMPLETE THIS PACKET IN ITS ENTIRETY IN BLUE AND BLACK PEN ONLY \*\*\***

- **FREE Sports Physicals** will be offered by the Lebanon School District tentatively on August 6, 2020
  - **This Free Physical Session is for ONLY Fall Student Athletes. We will have another Free physical session prior to the start of the winter season for all other student athletes**
  - Please stay tuned for updated information regarding Free Sports Physicals
    - School District website, Schoology, Facebook, Twitter, and Coaches
    - Due to COVID-19 there will be changes to how physicals are conducted
      - Appointments/sign-ups for a time slot
        - Please go to the following website or scan the following QR Code to Sign up
      - <https://forms.gle/nCsVWDYajeoJCrpb8>
    - Limited availability of appointments
    - We will be following CDC social distancing guidelines
    - **Student Athletes MUST have sections 1-5 COMPLETED in their entirety with ALL appropriate signatures prior to arrival for Free Sports Physical.**
    - **Incomplete Physical Packets will not be accepted, and you will not be permitted to get a free sports physical.**
- **Student-athletes who will be getting a Sports Physical done by their Primary Care Physician or other outside Physician:**
  - Authorized Date of Physical must be dated after **June 1 2020.**
  - This entire Physical Packet must be turned in, at the latest, to the **Athletic Office at the High School** by 3 PM prior to the start date of the sport season (See dates Below).
    - **Fall Season: August 13, 2020, (H.S. Football is August 6, 2020)**
    - **Winter Season: November 18, 2020**
    - **Spring Season: March 5, 2021**



\*\*\*\*\*VERY IMPORTANT\*\*\*\*\*

**ALL COMPLETED PHYSICAL PACKETS MUST GO TO THE HIGH SCHOOL ATHLETIC OFFICE, OR TO THE ATHLETIC TRAINER, NO EXCEPTIONS. DUE TO COVID-19 AND WORKING REMOTELY, PLEASE CALL THE ATHLETIC OFFICE AT (717) 270-6722 FOR DROP OFF INSTRUCTIONS.**

**PRIOR TO DROPPING OFF YOUR PHYSICAL PACKET, YOU MUST COMPLETE AN ONLINE FORM. YOU MUST ENTER ALL THE INFORMATION AS IT APPEARS IN SECTION 1 INTO THE FORM. PLEASE GO TO THE FOLLOWING WEBSITE OR SCAN THE QR CODE TO FILL OUT THE FORM**

<https://forms.gle/MAFPUMhio2FEczd7>



**Athletes with known cardiac conditions:** If you are getting a physical done at the high school on one of the above-mentioned dates; please provide the doctors a note from your most recent cardiac evaluation at the time of your physical. This will help the physicians. If you are NOT getting a physical done at the High School but have a known cardiac condition, or have been evaluated for a heart murmur, etc. you must provide the athletic department with an up to date clearance note from your cardiologist.

**Athletes who use an inhaler:** In accordance with the Pennsylvania Board of Medicine and Osteopathic Medicine, your child must have a physician's note giving permission to self-administer his/her inhaler or medication during extra-curricular activities. The note must include athlete's name, medication type, and dosage/frequency amounts with the authorization to self-administer. A copy of this authorization will be kept on file in the Athletic Training Room, and the original will be placed with the inhaler/medication and kept in the team's medical kit.



# 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 any 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 six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), 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 may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st or the conclusion of the current spring sports season.

**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 7 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, will determine whether Section 8 need be completed

## SECTION 1: PERSONAL AND EMERGENCY INFORMATION

**ALL FIELDS MUST BE COMPLETED, INDICATE N/A IF FIELD DOES NOT APPLY  
Must be completed in BLUE or BLACK Pen ONLY, NO PENCIL**

Athlete's Last Name(s): \_\_\_\_\_ First Name: \_\_\_\_\_ Sex: Male or Female

Student ID(Lunch#) \_\_\_\_\_ Grade for **2020-2021** School Year (circle one) **7 8 9 10 11 12**

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ House Phone# (N/A if no house phone) (717) \_\_\_\_\_

Current Home Address \_\_\_\_\_

**YOU MUST INDICATE A SPORT, DO NOT PUT A CHECK MARK OR LEAVE BLANK**

Fall Sport(s): \_\_\_\_\_ Winter Sport(s): \_\_\_\_\_ Spring Sport(s): \_\_\_\_\_

**IN CASE OF AN EMERGENCY PLEASE INDICATE WHO SHOULD BE CONTACTED 1<sup>ST</sup>, 2<sup>ND</sup>, AND 3<sup>RD</sup>. 1<sup>ST</sup> CONTACT NEEDS TO BE A PARENT OR GUARDIAN. PLEASE PROVIDE AT LEAST 2 DIFFERENT CONTACTS AND 2 DIFFERENT CONTACT PHONE NUMBERS**

1st Contact: \_\_\_\_\_  
First Name Last Name(s) Phone Relationship

2nd Contact: \_\_\_\_\_  
First Name Last Name(s) Phone Relationship

3rd Contact: \_\_\_\_\_  
First Name Last Name(s) Phone Relationship

**ALL INFORMATION BELOW MUST BE COMPLETED OR INDICATE (NONE)**

Family Physician's Name/Group: \_\_\_\_\_, MD or DO (circle one) Telephone # ( ) \_\_\_\_\_

Dentist Name/Group: \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Student's Allergies \_\_\_\_\_

Student's Health Condition(s) of which an Emergency Physician Should be Aware (Asthma, ADHD, ect) \_\_\_\_\_

Student's Prescription Medications and conditions of which they are being prescribed: \_\_\_\_\_

**Is the above-mentioned student athlete currently covered by medical insurance? YES or NO.**

I hereby certify that to the best of my knowledge all of the information in Section 1 is true and complete.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

## SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

THE STUDENT'S PARENT/GUARDIAN MUST COMPLETE ALL PARTS OF THIS FORM.

A. I hereby give my consent for \_\_\_\_\_ born on \_\_\_\_\_ who turned \_\_\_\_\_ on his/her last birthday, a student of Lebanon \_\_\_\_\_ School and a resident of the Lebanon School District (LSD) to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 2020-2021 school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

### SIGNATURE(S) REQUIRED, NOT A CHECK MARK

Fall Sports	Signature of Parent or Guardian
Cross Country	
Field Hockey	
Football	
Golf	
Soccer	
Girls' Tennis	
Girls' Volleyball	
Cheerleading	
Other	

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Competitive Spirit Squad	
Cheerleading	
Rifle	Not Offered at LSD
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	Not Offered at LSD
Girls' Lacrosse	Not Offered at LSD
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
Boys' Volleyball	
Other	

- A. **Understanding of eligibility rules:** I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at [www.piaa.org](http://www.piaa.org), include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.
- B. **Disclosure of records needed to determine eligibility:** To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.
- C. **Permission to use name, likeness, and athletic information:** I consent to PIAA's use of the herein named student's name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.
- D. **Permission to administer medical care:** I consent for a licensed medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices or Scrimmages and Contests. Additionally, I authorize a licensed medical provider to evaluate, treat, and rehabilitate injuries under the supervision of the Districts Team Physician or the student's physician's direction. Further, this authorization permits if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care. I further give permission to the school's athletic administration, coaches, and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student.
- E. **Confidentiality Statement:** The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school's athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).
- F. **Understanding the Re-Certification Process:** Any time your son or daughter is seen by a physician, a Re-Certification form will need to be filled out and signed by the treating physician. This is Section 7 and Section 8 of the CIPPE form, which is available in the Athletic Office, the Athletic Trainer's Office, or on the Lebanon School District website.
- G. **Understanding Sports Insurance Policy:** The Lebanon School District provides an all sports insurance policy to cover all senior high and middle school athletes, including cheerleaders & band members. This is considered secondary insurance for those students who are covered under another insurance plan. In the event of a sports related injury, the injury **MUST** be reported **IMMEDIATELY** to the appropriate school official; this will be the Athletic Trainer, Coach or Athletic Director. Insurance paperwork must be returned within 30 days of date of injury.
- H. **Understanding inherent Risk:** I understand and assume that with athletic competition there is risk of injury and acquiring a communicable disease such as, but not limited to, viral, bacterial and fungal infections due to close contact with infected athletes. LSD will take all precautions to limit athlete's risk of injury and exposure to infected participants.

I certify that I have read the above statements (A-H), understand its content, and agree to its terms.

I. Parent's/Guardian's Signature \_\_\_\_\_ Date    /    /

## SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

### What is a concussion?

A concussion is a disturbance in brain function that occurs following either a blow to the head or as a result of a violent shaking of the head. A concussion...

- Can change the way a student's brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been "dinged" or "had their bell rung."

All concussions are serious. A concussion can affect a student's ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student's brain time to heal.

### What are the symptoms of a concussion?

Concussions cannot be seen; however, in a potentially concussed student, **one or more** of the symptoms listed below may become apparent and/or that the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

### What should students do if they believe that they or someone else may have a concussion?

- **Students feeling any of the symptoms set forth above should immediately notify their Athletic Trainer, Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately notify their athletic trainer and/or coach.
- **The student should be evaluated** by his/her athletic trainer and a licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management. Lebanon School District (LSD) Athletic Team Physicians and Certified Athletic Trainers will evaluate all head injuries for the evidence of a concussion. The LSD and the LSD Physicians are responsible for the health and safety of all student athletes. In occasional instances this may require superseding your physician's recommendations. The LSD Sports Medicine staff will follow a step-wise return to play procedure for all concussions beginning with removal from play, appropriate treatment until symptom free, and eventual stepwise progression back to play. The procedures are recognized by the PIAA's Sports Medicine Advisory Committee as well as by National and International conferences on concussion management as appropriate standards of care.
- **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long-term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

**How can students prevent a concussion?** Every sport is different, but there are steps students can take to protect themselves.

- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:
  - The right equipment for the sport, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time the student Practices and/or competes
- Follow the Coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

**If a student believes they may have a concussion:** Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

### What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

### How common is sudden cardiac arrest in the United States?

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

### Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

### What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it.

### Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

Information about SCA symptoms and warning signs.

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may also hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

Removal from play/return to play

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA.

\_\_\_\_\_  
Signature of Student-Athlete Print Student-Athlete's Name

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian Print Parent/Guardian's Name

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_



**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?	<input type="checkbox"/>	<input type="checkbox"/>	23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>																
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>																
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>																
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>																
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>																
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>																
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you ever had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>																
9. Has a doctor ever told you that you have (check all that apply):			<b>CONCUSSION OR TRAUMATIC BRAIN INJURY</b>																		
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur			31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>																
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	33. Do you experience dizziness and/or headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>																
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>																
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>																
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>																
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>																
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>																
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:	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>																
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>																
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:	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>																
<table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%;">Head</td> <td style="width: 12.5%;">Neck</td> <td style="width: 12.5%;">Shoulder</td> <td style="width: 12.5%;">Upper arm</td> <td style="width: 12.5%;">Elbow</td> <td style="width: 12.5%;">Forearm</td> <td style="width: 12.5%;">Hand/ Fingers</td> <td style="width: 12.5%;">Chest</td> </tr> <tr> <td>Upper back</td> <td>Lower back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/shin</td> <td>Ankle</td> <td>Foot/ Toes</td> </tr> </table>	Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest	Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes			43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest														
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes														
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>																
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>																
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>																
			<b>FEMALES ONLY</b>																		
			47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>																
			48. How old were you when you had your first menstrual period?	_____	_____																
			49. How many periods have you had in the last 12 months?	_____	_____																
			50. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>																

#’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 \_\_\_\_\_

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 <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 SP (circle one) Certification Date of CIPPE \_\_\_\_/\_\_\_\_/\_\_\_\_

**Must be dated after 6/1/2020**