# 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_____

_____

_____

_____

(please turn page over)

## 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 _____ School and a resident of the _____ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____ - 20____ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

| Sport | Signature of Parent or Guardian |
|---|---|
| Baseball (Spring) | |
| Basketball (Winter) | |
| Bowling (Winter) | |
| Cross Country (Fall) | |
| Field Hockey (Fall) | |
| Football (Fall) | |
| Golf (Fall) | |
| Gymnastics (Winter) | |
| Lacrosse (Spring) | |
| Rifle (Winter) | |
| Soccer (Fall) | |
| Soccer-Girls (Spring) | |
| Softball (Spring) | |
| Swimming & Diving | |
| Tennis-Girls (Fall) | |
| Tennis-Boys (Spring) | |
| Track-Indoor (Winter) | |
| Track & Field (Spring) | |
| Volleyball-Girls (Fall) | |
| Volleyball-Boys (Spring) | |
| Water Polo (Fall) | |
| Wrestling (Winter) | |
| Other | |

**B. 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, 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.

Parent's/Guardian's Signature _____Date____/____/_____

**C. 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.

Parent's/Guardian's Signature _____Date____/____/_____

**D. 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 reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent's/Guardian's Signature _____Date____/____/_____

**E. Permission to administer emergency medical care:** I consent for an emergency 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, Scrimmages, and/or Contests. 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.

Parent's/Guardian's Signature _____Date____/____/_____

-more-

Student's Name _____ Age_____ Grade_____

## SECTION 3: HEALTH HISTORY

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

| | | Yes | No |
|---|---|---|---|
| 1. | Has a doctor ever denied or restricted your participation in sport(s) for any reason? | ☐ | ☐ |
| 2. | Do you have an ongoing medical condition (like asthma or diabetes)? | ☐ | ☐ |
| 3. | Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | ☐ | ☐ |
| 4. | Do you have allergies to medicines, pollens, foods, or stinging insects? | ☐ | ☐ |
| 5. | Have you ever passed out or nearly passed out DURING exercise? | ☐ | ☐ |
| 6. | Have you ever passed out or nearly passed out AFTER exercise? | ☐ | ☐ |
| 7. | Have you ever had discomfort, pain, or pressure in your chest during exercise? | ☐ | ☐ |
| 8. | Does your heart race or skip beats during exercise? | ☐ | ☐ |
| 9. | Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection | | |
| 10. | Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) | ☐ | ☐ |
| 11. | Has anyone in your family died for no apparent reason? | ☐ | ☐ |
| 12. | Does anyone in your family have a heart problem? | ☐ | ☐ |
| 13. | Has any family member or relative died of heart problems or of sudden death before age 50? | ☐ | ☐ |
| 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, that 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 Hand/ Fingers Chest<br>Upper back Lower back Hip Thigh Knee Calf/shin 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? | ☐ | ☐ |
| 23. | Has a doctor every told you that you have asthma or allergies? | ☐ | ☐ |
| 24. | Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? | ☐ | ☐ |
| 25. | Is there anyone in your family who has asthma? | ☐ | ☐ |
| 26. | Have you ever used an inhaler or taken asthma medicine? | ☐ | ☐ |
| 27. | Were you born without or are your missing a kidney, an eye, a testicle, or any other organ? | ☐ | ☐ |
| 28. | Have you had infectious mononucleosis (mono) within the last month? | ☐ | ☐ |
| 29. | Do you have any rashes, pressure sores, or other skin problems? | ☐ | ☐ |
| 30. | Have you had a herpes skin infection? | ☐ | ☐ |
| 31. | Have you ever had a head injury or concussion? | ☐ | ☐ |
| 32. | Have you been hit in the head and been confused or lost your memory? | ☐ | ☐ |
| 33. | Have you ever had a seizure? | ☐ | ☐ |
| 34. | Do you have headaches with exercise? | ☐ | ☐ |
| 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 failing? | ☐ | ☐ |
| 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? | ☐ | ☐ |
| | **FEMALES ONLY** | | |
| 47. | Have you ever had a menstrual period? | ☐ | ☐ |
| 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? | ☐ | ☐ |

| No(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____/____/_____

(please turn page over)

## 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___/____/___

## SECTION 5: PIAA RE-CERTIFICATION BY PARENT/GUARDIAN

**This form must be completed by the parent/guardian of any student who (1) completed a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE) between June 1st and participation in the student's first sport season's first Practice of the same school year; and (2) is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year. The Principal, or Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY and make a determination as to whether the student should be re-evaluated and re-certified by an Authorized Medical Examiner pursuant to Section 6.**

## SUPPLEMENTAL HEALTH HISTORY

Student's Name _____ Age_____ Grade_____

**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):**

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 # (  )_____

**SUPPLEMENTAL HEALTH HISTORY:**

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

| | | Yes | No |
|---|---|---|---|
| 1. | Have you sustained an illness and/or injury related to sport(s) since completion of the CIPPE? | ☐ | ☐ |
| 2. | Have you sustained an illness and/or injury NOT related to sport(s) since completion of the CIPPE? | ☐ | ☐ |
| 3. | Have you been confined to an institution and/or at home as a result of an illness and/or injury since completion of the CIPPE? | ☐ | ☐ |
| 4. | Have you had surgery since completion of the CIPPE? | ☐ | ☐ |
| 5. | Have you experienced dizzy spells, blackouts, and/or unconsciousness? | ☐ | ☐ |
| 6. | Have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? | ☐ | ☐ |
| 7. | Have you experienced any new health problems since completion of the CIPPE? | ☐ | ☐ |
| 8. | Are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills since completion of the CIPPE? | ☐ | ☐ |
| 9. | Do you have any concerns that you would like to discuss with a doctor? | ☐ | ☐ |

| No(s). | Explain "Yes" answers here: |
|---|---|
| | |
| | |

**SUBSEQUENT SPORT(S) TO BE PLAYED:**_____ **SEASON:** Fall Winter Spring (circle one)

**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____/____/_____

**NOTE:** If any **SUPPLEMENTAL HEALTH HISTORY** questions are either checked yes or circled, the Principal, or Principal's designee, of the herein named student's school shall require the student to complete Section 6 prior to being eligible to participate in sport(s) identified above.

(please turn page over)

## Section 6: PIAA Comprehensive Pre-Participation Physical Re-Evaluation And Re-Certification By Authorized Medical Examiner

Must be completed and signed by an Authorized Medical Examiner and turned in to the Principal, or the Principal's designee, of the student's school prior to participation in second and subsequent sport in the same school year.

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 SUPPLEMENTAL HEALTH HISTORY, performed a physical re-evaluation of the herein named student, and, on the basis of such re-evaluation and the student's SUPPLEMENTAL 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 5 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___/____/___

## Section 7: CIPPE MINIMUM WRESTLING WEIGHT CLASSIFICATION

**INSTRUCTIONS**

Pursuant to the Weight Control Program adopted by PIAA, prior to the participation by any student in interscholastic wrestling, the minimum weight classification at which the student may wrestle during the season must be (1) certified to by an Authorized Medical Examiner, and (2) established NO EARLIER THAN six weeks prior to the first Regular Season Contest day of the wrestling season and NO LATER THAN the Monday preceding the first Regular Season Contest day of the wrestling season. This certification shall be provided to and maintained by the student's Principal, or the Principal's designee.

In certifying to the minimum weight classification, the Authorized Medical Examiner shall first make a determination of the student's Urine Specific Gravity/Body Weight and Percentage of Body Fat, or shall be given that information from a person authorized to make such an assessment ("the Assessor"). This determination shall be made consistent with National Federation of State High School Associations (NFHS) Wrestling Rule 1, Competition, Section 3, Weight-Control Program, which requires, in relevant part, hydration testing with a specific gravity not greater than 1.025, and an immediately following body fat assessment, as determined by the National Wrestling Coaches Association (NWCA) Optimal Performance Calculator, Scholastic Edition (together, the "Initial Assessment").

Where the Initial Assessment establishes a percentage of body fat below 7% for a male or 12% for a female, the Authorized Medical Examiner may require that the student wrestle at a minimum weight classification one or more weight classifications above what would otherwise be appropriate based upon the student's Minimum Wrestling Weight, as established by the Initial Assessment. Under these circumstances, the Authorized Medical Examiner may NOT allow a wrestler to participate at a minimum weight classification below that determined by the Initial Assessment.

For all wrestlers, the certified minimum wrestling weight class shall be certified to by an Authorized Medical Examiner. The Authorized Medical Examiner shall initial the minimum wrestling weight class, pursuant to the Initial Assessment.

Student's Name _____ Age_____ Grade_____

Enrolled in _____ School

**INITIAL ASSESSMENT**

I hereby certify that I have conducted an Initial Assessment of the herein named student consistent with the NWCA Optimal Performance Calculator, Scholastic Edition, and have determined as follows:

Urine Specific Gravity/Body Weight _____/_____Percentage of Body Fat _____Minimum Wrestling Weight_____

Assessor's Name (print/type)_____Assessor's I.D. #_____

Assessor's Signature_____Date_____/_____/_____

**CERTIFICATION**

Consistent with the instructions set forth above and the Initial Assessment, I have determined that the herein named student is allowed to wrestle at the following minimum weight classification during the 20____ - 20____ wresting season (**the Authorized Medical Examiner may initial only <u>one</u> of the following senior high or junior high/middle school weight classes**):

**SENIOR HIGH SCHOOL (14 Weight Classifications):**

| | | | | | | |
|---|---|---|---|---|---|---|
| 103 lbs. _____ | 112 lbs. _____ | 119 lbs. _____ | 125 lbs. _____ | 130 lbs. _____ | 135 lbs. _____ | 140 lbs. _____ |
| 145 lbs. _____ | 152 lbs. _____ | 160 lbs. _____ | 171 lbs. _____ | 189 lbs. _____ | 215 lbs. _____ | 285 lbs. _____ |

**JUNIOR HIGH/MIDDLE SCHOOL (18 Weight Classifications):**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 75 lbs. ___ | 80 lbs. ___ | 85 lbs. ___ | 90 lbs. ___ | 95 lbs. ___ | 100 lbs. ___ | 105 lbs. ___ | 110 lbs. ___ | 115 lbs. ___ |
| 122 lbs. ___ | 130 lbs. ___ | 138 lbs. ___ | 145 lbs. ___ | 155 lbs. ___ | 165 lbs. ___ | 185 lbs. ___ | 210 lbs. ___ | 250 lbs. ___ |

Authorized Medical Examiner's Name (print/type) _____ License #_____

Address_____ Phone (  )_____

Authorized Medical Examiner's Signature_____MD, DO, PAC, CRNP, or SNP Date_____/_____/_____
(circle one)

**NOTE:** Any athlete who disagrees with the Initial Assessment may appeal the assessment results one time by having a second assessment performed. The second assessment must utilize either Air Displacement Plethysmography (Bod Pod) or Hydrostatic Weighing testing to determine body fat percentage. Results obtained at the second assessment shall supersede the Initial Assessment and are automatically accepted; no further appeal by any party is permitted. All costs incurred in the second assessment are the responsibility of those appealing the Initial Assessment. The urine specific gravity testing will be conducted and the athlete will need to have a result of less than or equal to 1.025 in order for the second assessment to proceed.