**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 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 (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 performed 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, will then determine whether Section 6 need be completed.**

**SECTION 1: PERSONAL AND EMERGENCY INFORMATION**

**PERSONAL INFORMATION**

Student’s Name Male/Female (circle one)

Date of Student’s Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ Age of Student on Last Birthday: \_\_\_\_ Grade for Current School Year: \_\_\_\_

Current Physical Address

Current Home Phone # ( ) Parent/Guardian Current Cellular Phone # ( )

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

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EMERGENCY INFORMATION** |  |  |  |  |  |  |  |  |  |  |  |
| Parent’s/Guardian’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

**Revised: October 8, 2009** (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.

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

**B. Understanding of eligibility rules:** I hereby acknowledge that I am familiar with the requirements of PIAAconcerning 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 namedstudent 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 namedstudent’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 toadminister 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\_\_\_\_/\_\_\_\_/\_\_\_\_\_

**F. Understanding of risk of concussion and head injury:** I hereby acknowledge that I am familiar with the natureand risk of concussion and head injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or head injury. Information relevant to concussion in high school sports is available on the PIAA Web site at www.piaa.org/piaa-for/sports-med.

Parent’s/Guardian’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Revised: May 20, 2010** -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?

1. Do you have an ongoing medical condition

(like asthma or diabetes)?

1. Are you currently taking any prescription or

nonprescription (over-the-counter) medicines or pills?

1. Do you have allergies to medicines, pollens,

foods, or stinging insects?

1. Have you ever passed out or nearly passed

out DURING exercise?

1. Have you ever passed out or nearly passed

out AFTER exercise?

1. Have you ever had discomfort, pain, or

pressure in your chest during exercise?

1. Does your heart race or skip beats during

exercise?

1. Has a doctor ever told you that you have

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | (check all that apply): |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | High blood pressure |  | Heart murmur |  |  |  |  |  |  |  |
| 10. |  |  | High cholesterol |  |  | Heart infection |  |  |  |  |  |  |  |
|  | 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 | Elbow | Forearm | Hand/ | Chest |  |
|  |  |  |  |  | arm |  |  | Fingers |  |  |  |  |
| Upper |  |  | Lower | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/ |  |
| back |  |  | back |  |  |  |  |  |  |  |  | Toes |  |
| 20. | Have you ever had a stress fracture? |  |  |  |  |  |  |  |  |

1. 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?

Yes No

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?

**CONCUSSION OR HEAD INJURY**

31. Have you ever had a concussion (i.e. bell

rung, ding, head rush) or head 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?

1. 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?

1. 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?

1. How old were you when you had your first menstrual period?
2. How many periods have you had in the last 12 months?

50. Are you pregnant?

|  |  |
| --- | --- |
| **#’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\_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Revised: May 20, 2010** (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 (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) \_\_\_\_\_\_ BP\_\_\_\_\_/\_\_\_\_\_ (\_\_\_\_\_/\_\_\_\_\_ , \_\_\_\_\_/\_\_\_\_\_) RP\_\_\_\_\_\_\_

If either the 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 |  |  |  |
|  |  |  |  |  |
|  | 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)* | Date of CIPPE \_\_\_/\_\_\_\_/\_\_\_ |  |

**SECTION 5: 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 6, 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) |
| Date of Student’s Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ | Age of Student on Last Birthday: \_\_\_\_\_\_ Grade for Current 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 |  |  |  |  |  |  |
| 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 |  |  |  |  | Yes | No |
| 1. Since completion of the CIPPE, have you |  |  |  |  | 4. Since completion of the CIPPE, have you |  |  |  |  |  |
| sustained an illness and/or injury that |  |  |  |  | experienced any episodes of unexplained |  |  |  |  |  |
| required medical treatment from a licensed |  |  |  |  | shortness of breath, wheezing, and/or chest |  |  |  |  |  |
| physician of medicine or osteopathic |  |  |  |  | pain? |  |  |  |  |  |  |  |  |  |  |  |  |
| medicine? |  |  |  |  |  |  | 5. Since completion of the CIPPE, are you |  |  |  |  |  |  |  |
| 2. Since completion of the CIPPE, have you |  |  |  |  |  |  | taking any NEW prescription or non- |  |  |  |  |  |
| had a concussion (i.e. bell rung, ding, head |  |  |  |  | prescription (over-the-counter) medicines or |  |  |  |  |  |
| rush) or head injury? |  |  |  |  |  |  |  | pills? |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. Since completion of the CIPPE, have you |  |  |  |  | 6. Do you have any concerns that you would |  |  |  |  |  |  |  |
| experienced dizzy spells, blackouts, and/or |  |  |  |  | like to discuss with a physician? |  |  |  |  |  |  |  |  |  |  |  |  |
| unconsciousness? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **#’s** |  |  | **Explain “Yes” answers here:** |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**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\_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Revised: May 20, 2010**

**Section 6: CERTIFICATION BY LICENSED PHYSICIAN OF MEDICINE OR OSTEOPATHIC MEDICINE**

This Form must be completed for any student who, subsequent to completion of Sections 1 through 4 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 6 may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to the Principal, or the Principal’s designee, of the student's school.

**NOTE: The physician completing this Form must first review Sections 3 and 4 of the herein named student's previously completed CIPPE Form. Section 5 must also be reviewed if both 1) this Form is being used by the herein named student to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in a subsequent sport season in the same school year AND 2) the herein named student either checked yes or circled any Supplemental Health History questions in Section 5.**

**If the physician completing this Form is clearing the herein named student subsequent to that student sustaining a concussion or head injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.**

Student's Name: Age Grade

Enrolled in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School

Condition(s) Treated Since Completion of the Herein Named Student’s CIPPE Form:

**A. GENERAL CLEARANCE:** Absent any illness and/or injury, which requires medical treatment, subsequent to thedate set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with no restrictions, except those, if any, set forth in Section 4 of that student’s CIPPE Form.

Physician’s Name (print/type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD or DO *(circle one)* Date\_\_\_\_\_\_\_\_\_\_\_\_

**B. LIMITED CLEARANCE:** Absent any illness and/or injury, which requires medical treatment, subsequent to the dateset forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with, in addition to the restrictions, if any, set forth in Section 4 of that student’s CIPPE Form, the following limitations/restrictions:

1.

2.

3.

4.

Physician’s Name (print/type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD or DO *(circle one)* Date\_\_\_\_\_\_\_\_\_\_\_\_

**Revised: May 20, 2010**

**Section 7: CIPPE MINIMUM WRESTLING WEIGHT**

**INSTRUCTIONS**

Pursuant to the Weight Control Program adopted by PIAA, prior to the participation by any student in interscholastic wrestling, the Minimum Wrestling Weight (MWW) at which the student may wrestle during the season must be 1) certified to by an Authorized Medical Examiner (AME) 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 (See NOTE 1). This certification shall be provided to and maintained by the student’s Principal, or the Principal’s designee.

In certifying to the MWW, the AME 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 (OPC) (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 student must obtain an AME’s consent to participate.

For all wrestlers, the MWW must be certified to by an AME.

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 OPC, and have determined as follows:

Urine Specific Gravity/Body Weight \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Percentage of Body Fat \_\_\_\_\_\_\_\_\_ MWW \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 certified to wrestle at the MWW of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ during the 20\_\_\_\_ - 20\_\_\_\_ wresting season.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| AME’s Name (print/type) |  |  | License # |  |
| Address |  |  | Phone ( | ) |  |  |

AME’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD, DO, PAC, CRNP, or SNP Date of Certification \_\_\_/\_\_\_/\_\_\_

(circle one)

For an appeal of the Initial Assessment, see NOTE 2.

**NOTES:**

1. For senior high school wrestlers coming out for the Team AFTER the Monday preceding the first Regular Season Contest day of the wrestling season the OPC will remain open until January 15th and for junior high/middle school wrestlers coming out for the Team AFTER the Monday preceding the first Regular Season Contest day of the wrestling season the OPC will remain open all season.
2. Any athlete who disagrees with the Initial Assessment may appeal the assessment results one time by having a second assessment, which shall be performed prior to the athlete’s first Regular Season wrestling Contest and shall be consistent with the athlete’s weight loss (descent) plan. Pursuant to the foregoing, results obtained at the second assessment shall supersede the Initial Assessment; therefore, no further appeal by any party shall be permitted. The second assessment shall utilize either Air Displacement Plethysmography (Bod Pod) or Hydrostatic Weighing testing to determine body fat percentage. The urine specific gravity testing shall be conducted and the athlete must obtain a result of less than or equal to 1.025 in order for the second assessment to proceed. All costs incurred in the second assessment shall be the responsibility of those appealing the Initial Assessment.

**Revised: May 20, 2010**