

# **Bethel Park High School**

## ***Sports Physicals***

*Allegheny General Hospital Sports Medicine will be providing pre-participation physical exams for high school athletes participating in the upcoming sports seasons.*

***Location:*** AGH Human Motion Bethel Park

***Date:*** Saturday October 10, 2009  
*(Additional dates and locations will be available)*

***Time:*** 8:00am to 10:00am

***Cost:*** \$10.00 (cash or checks made payable to AGH)

***Please call 1-877-284-2000 for an appointment***

### ***Reminder:***

- *One complete physical is required by the PIAA to participate in high school athletics*
- *The physical examination can be completed by your family physician or by AGH on the above date.*
- *If this is a re-certification exam you only need to fill out Section 5.*
- *Physicals will last approximately 45 minutes, please wear comfortable clothing.*

### ***Additional reminder:***

*In order to have a physical examination completed, the HIPPA form must be signed by a parent or legal guardian, or athlete if they are over 18.*



NAME \_\_\_\_\_ SPORT \_\_\_\_\_

MALE/FEMALE \_\_\_\_\_ HOMEROOM \_\_\_\_\_ CURRENT SCHOOL YEAR \_\_\_\_\_

CONTACT TELEPHONE NUMBER \_\_\_\_\_

Please circle the grade level that you participated in this sport (including this season):

7      8      9      10      11      12

FOR STUDENTS IN GRADES 9 – 12 ONLY: How many semesters have you been in school beyond 8<sup>th</sup> grade (including this semester)?

(circle one)    1      2      3      4      5      6      7      8      9      10      11      12

**STUDENT**

I am aware that playing or practicing to play/participate in any sport can be a dangerous activity involving many risks of injury. I understand that the dangers and risks of playing or practicing to play/participate include but are not limited to death, serious neck injury and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, bones, joints, ligaments, muscles, tendons and other aspects of the muscular-skeletal system, and other serious injury or impairment to other parts of my body, general health and well being.

Because of these dangers of participation in the above sport, I recognize the importance of following coaches' instructions regarding playing techniques, training and team rules, and agree to follow such instructions. I further agree to abide by the rules, regulations and other material contained in the Bethel Park Athletic Handbook.

As a result of the Bethel Park School District (BPSD) providing me the opportunity to try out for the above sport and to engage in all activities related to the team, including but not limited to trying out, practicing or playing/participating in that sport, I hereby assume all the risks outlined above.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

**PARENT / LEGAL GUARDIAN**

As the parent/legal guardian of the above named student, I have read the STUDENT section above and understand that all sports can involve risk of injury including but not limited to those risks outlined above.

As a result of the BPSD providing my child/ward the opportunity to try out for the above named sport and to engage in all activities related to the team, I hereby give my permission for him/her to participate in that sport for the school year indicated.

I understand that the BPSD does not provide medical insurance coverage for its athletes and that our child must be enrolled in some type of medical insurance coverage before participating in interscholastic athletics. We also agree not to hold the BPSD, its officers or its employees, liable for any medical or hospital care or expense. Therefore, I am responsible for any medical care and all related expenses for my child which resulted from any cause whatsoever in connection with the sport listed above.

I understand that as a parent/legal guardian, I am financially responsible for any lost or non-returned school issued uniform/equipment. It is important that all items be returned or paid for so that the following year's team may receive the same benefits of representing their school during athletic contests. Failure to comply will result in the student's name appearing on the school's Obligation List.

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date



**Authorization for Release  
Of Protected Health Information  
For Athletic Pre-Participation  
Physical Exams**



**Athlete's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Address** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Age:** \_\_\_\_\_

\_\_\_\_\_ **Sport:** \_\_\_\_\_

I, \_\_\_\_\_ (printed name of parent, legally authorized representative, or athlete if over 18) hereby authorize Allegheny General Hospital and the Bethel Park School District to administer my son's/daughter's pre-participation physical examination, **and/or** I authorize the release of the pre-participation physical examination or a copy of this examination to: School Administration, Athletic Directors, Secretaries, Nurses, Coaches, Athletic Trainers and Team Physicians. The information being released is to inform the aforementioned administration about the status of the pre-participation physical examinations.

I understand that this authorization is subject to revocation at any time, except to the extent that Allegheny General Hospital has already taken action in reliance upon it. This authorization is valid for 1 calendar year from the date below. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set fourth above unless I revoke this authorization in writing to the AGH (1307 Federal Street, Suite 500, Pittsburgh, PA 15212). I understand that participants may disclose information which I authorize them to receive.

\_\_\_\_\_ Date \_\_\_\_\_ Witness initials \_\_\_\_\_  
Signature of Parent or Legal Guardian  
(Athlete may sign if over the age of 18)

**INSURANCE INFORMATION:**

It is our understanding that our child/ward must be enrolled in some type of insurance coverage before participation in interscholastic athletics can be approved by school officials. We will not hold the Bethel Park School District, its officers, or its employees liable for any injuries which may be sustained by our child beyond the limits of the insurance policy while he/she is participating in the program.

Name of Insurance Policy or Company: \_\_\_\_\_

Policy / ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_

I hereby give my permission to the EMS/Athletic Trainer to evaluate and treat my son/daughter in case of injury or illness. I also give my consent to the hospital/physician to administer emergency care and/or treatment to my child/ward.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

# 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 1<sup>st</sup> and shall be effective, regardless of when performed during a school year, until the next May 31<sup>st</sup>.

**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 \_\_\_\_\_ 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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](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.

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION 3: 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"/>	22.	Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have an ongoing medical condition (like asthma or diabetes)?	<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"/>
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<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"/>
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	25.	Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever passed out or nearly passed out AFTER 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"/>
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28.	Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Does your heart race or skip beats 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"/>
9.	Has a doctor ever told you that you have (check all that apply):			30.	Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> High blood pressure			31.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> High cholesterol			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.	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34.	Do you have headaches with exercise?	<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 died of heart problems or of 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, that 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"/>
	Head    Neck    Shoulder    Upper arm    Elbow    Forearm    Hand/ Fingers    Chest			43.	Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
	Upper back    Lower back    Hip    Thigh    Knee    Calf/shin    Ankle    Foot/ Toes			44.	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	45.	Do you limit or carefully control what you eat?	<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"/>	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"/>

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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.

## Section 6: PIAA COMPREHENSIVE PRE-PARTICIPATION PHYSICAL RE-EVALUATION AND RE-CERTIFICATION BY AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by either (1) the AME who performed the initial pre-participation physical evaluation, or (2) another AME who has reviewed the previously completed Sections 1 through 5 of this CIPPE Form. Upon completion and signature, and prior to the student's participation in a second and subsequent sport in the same school year, this Section must be 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 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) \_\_\_\_\_

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

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

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

## 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. 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, 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 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 Optimal Performance Calculator, Scholastic Edition, 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\_\_\_\_ wrestling season.

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

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

AME's Signature \_\_\_\_\_ MD, DO, PAC, CRNP, or SNP Date of Certification \_\_\_\_/\_\_\_\_/\_\_\_\_  
(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.