Spring 2019 SPORTS PHYSICAL ANNOUNCEMENT

A physical examination is necessary for an athlete to be eligible to participate in an interscholastic sport. The physical must be completed after June 1st, 2018 for fall sports participation and shall be effective, regardless of when performed during a school year until the next June 1st.

A reexamination or re-certification is required for each subsequent sports season if the student (a) suffers an illness or injury which renders the student unable to participate in 25% or more of the Regular Season Contests in the immediately preceding sports season; and/or (b) suffers an illness or injury which resulted in absence from school for ten (10) or more days and/or which requires surgery.

Sports physicals can be administered by your Personal Care Physician, MedExpress or the equivalent.

BE SURE TO BRING THE PHYSICAL PACKET WITH YOU!

MedExpress
1613 North Atherton Street
State College, PA
(814) 238-1066
Open 7 days a week from 8:00 AM – 8:00 PM. Cost is $30.00. If you need your driver's license exam get both for $30.00.

If you have any questions or request further information, please contact the Athletic Office - 353-5322.

PARENT INFORMATIONAL MEETING – Monday, February 11, 2019 in the HS Cafeteria at 6:00 pm. It is imperative that one representative from each student athletes family be present at this meeting.

The first day of Spring Sports is Monday, March 4, 2019. Please have your physical complete and turned into the Athletic Trainer before Thursday, February 28, 2019. Any physical turned in after February 28th, may cause delay in participation on March 4th.

STUDENT ATHLETE DEMOGRAPHICS

Last Name:_____ First Name:_____ MI:_____

Date Of Birth:_____ Current Age:_____ District Enrollment Date:_____

Place of Enrollment: (____) BAHS (____) BAMS OTHER: (i.e. – Cyber, Charter, Home)_____

Grade for the 2018-2019 School Year: 7th 8th 9th 10th 11th 12th

Have you repeated any grades since 7th grade? YES NO

If so, which grade(s)? _____

Please indicate which sport below: (i.e.: Girls Soccer, Boys Basketball, Track and Field)

FALL Sport:_____ WINTER Sport:_____ SPRING Sport:_____

Which years have you competed in this sport for BASD? 7th 8th 9th 10th 11th 12th

Which years at another PIAA school district? N/A 7th 8th 9th 10th 11th 12th

District:_____

Parent Name:_____Email:_____Cell:_____Relationship:_____

Parent Name:_____Email:_____Cell:_____Relationship:_____

BELLEFONTE ATHLETE HANDBOOK SIGN-OFF

The current Athlete Handbook is available on-line. Go to the Bellefonte Area School District web site; from there go to the Athletic web page and the link to the handbook is located on the left side of the page.

By signing below, I confirm that I have read and understand the current Athlete Handbook for the Bellefonte Area School District.

_____ _____ _____

(*Parent/Guardian Name*) (*Signature*) (*Date*)

_____ _____ _____

(*Athlete's Name*) (*Signature*) (*Date*)

☐ Check here if you would like a paper copy of the current handbook.

BELLEFONTE AREA SCHOOL DISTRICT
CONSENT FOR EMERGENCY MEDICAL TREATMENT

*Athlete's name:*_____ *Birthdate:*_____ *Grade:*_____ *Date:* _____

In the event of an emergency requiring medical attention, I expect every measurable attempt be made to contact me. In case I cannot be reached, I grant permission for any immediate treatment deemed necessary by the attending physician, dentist, or other medical personnel designated by the Bellefonte Area School District's Sport's Medicine staff to attend to my child. I expect every effort will be made to contact me in order to receive my specific authorization before any treatment or hospitalization is undertaken.

This authorization does not cover major surgery unless formally decreed prior by two licensed physicians or dentists.

*Facts concerning my child's medical history including allergies, medications being taken and physical impairments to which medical personnel should be alerted to:*_____

_____.

*Check One:*_____ I GIVE MY CONSENT *OR*_____ *I DO NOT GIVE MY CONSENT*

*Parent/Guardian Signature:*_____ Cell:_____

Address _____ Home Phone:_____

_____ Bus. Phone: _____

In the event emergency treatment is required, I wish medical personnel to take the following action: _____

Dr.:_____ Ph:_____

Dentist: _____ Ph:_____

Emergency Contact(s):

Name:	Relationship:	Phone:
_____	_____	_____
_____	_____	_____

BELLEFONTE AREA SCHOOL DISTRICT
MEDICAL INSURANCE INFORMATION AND WAIVER

This is to certify that my son/daughter_____ a student at the Bellefonte Area Schools, who is participating in the interscholastic athletic program, is covered with medical insurance under my personal policy or at my place of employment. (Note: Please check to determine that your hospitalization will cover participation in interscholastic sports, if your child is not covered by an insurance policy the district recommends the purchase of school insurance.) I herby waive any claim against the Bellefonte Area School District resulting from failure of the District to cover him/her with such medical insurance and assume all liability therefore.

_____ I certify that my son/daughter is covered with medical insurance for the period of_____ to_____ and have signed and completed requested insurance information.

_____ My son/daughter is not covered by medical insurance at this time, however in the event that coverage is obtained I will notify the Athletic Trainer and provide the appropriate insurance information. (Parent/Guardian signature and date needed on following line.

*Parent/Guardian Signature:*_____ *Date:* _____

*Insurance Company:*_____ *Employer:*_____

*Insurance Policy Number:*_____

ACKNOWLEDGEMENT OF RISK

As with any physical activity, I am aware that with the participation in sports there lies a potential risk of injury. I am aware that giving consent to my child for participation in the interscholastic athletic program there is a risk of injury to my child and this risk increases with participation in contact sports.

I acknowledge and accept the risks inherent in my child's sport(s) and with the travel involved. With this knowledge in mind, I grant permission for my child to participate in the Bellefonte Area School District's interscholastic athletic program.

*Parent/Guardian Signature:*_____

I have read the above paragraphs and fully understand the content and agree to take on the responsibility to follow the coach or athletic trainer's instructions in order to reduce the possibility of serious injury.

*Student Athlete's Signature:*_____

I, the undersigned and legal guardian of_____, acknowledge and understand that as a member of one of the Bellefonte Area School District sports teams that student-athletes being dismissed early from school for events may walk on School Street between the Middle School and High School without school personnel supervision.

Student-athletes are to exit their respective building through the main entrance. Upon exiting, they are to walk directly from the Middle School to the High School or vice-versa with no stops along the way. Student-athletes should use the sidewalks and pedestrian walkways obeying traffic rules.

_____ _____

Signature of Parent Date

_____ _____

Signature of Student-athlete Date

Bellefonte Area School District
Injury Policy

The BASD Licensed Athletic Training Staff, along with its sports medicine team members, strive to protect and return injured student-athletes to practice and competition as quickly and safely as possible.

The Licensed Athletic Training Staff possesses the knowledge and skills in providing injury recognition, injury prevention, emergency care, evaluation and assessment, immediate care, treatment, rehabilitation, and reconditioning for student athletes.

Sports participation in athletics involves an inherent risk for injury and the student-athlete and coaching staff must share in the responsibility of injury management and prevention through:

1. Following safety protocols
2. Communicating and reporting injuries to the licensed athletic training staff in a timely and efficient manner

Any student-athlete participating and individuals coaching school sponsored activities must adhere to this policy.

Student-Athletes Injured in Practice, Competition, Other Activity

1. ALL INJURIES occurring during BASD sponsored events, practices, and games must be reported to the athletic trainer(s) at BASD. The student-athlete must be evaluated by the athletic training staff prior to returning to practice or completion.

2. FOLLOWING THE EVALUATION FOR AN INJURY, medical referrals for further recommendation and evaluation by a licensed physician will be made when deemed necessary. Follow-up re-evaluations will be performed the following practice or event day to determine the level or ability of the student-athlete's participation and/or the need for that individual to seek further medical attention for their injury. BASD LAT staff can assist you in making a physician appointment if needed as outlined in the policies and procedures manual.

3. ALL INJURIES OCCURING AT AWAY EVENTS (GAMES, MEETS, MATCHES, TOURNAMENTS, and COMPETITIONS) must be reported within 24 hours of the away athletic event. It is the head coach's responsibility to contact the licensed athletic training staff within that period of time via phone call, text, or email regarding the injury. The student-athlete will refrain from participating in practice or competition until they have been cleared to return by the BASD athletic training staff. This is necessary to reduce the risk of further injury and liability for the LAT staff, coaching staff, and the district.

4. IN THE EVENT OF A MEDICAL EMERGENCY FROM AN INJURY OCCURRING AT AWAY EVENTS (GAMES, MEETS, MATHCES, TOURNAMENTS, and COMPETITIONS) student athlete should seek immediate medical attention and report that information regarding the injury within 24 hours of the away athletic event to the BASD LAT staff. It is the head coach's responsibility to contact the licensed athletic training staff within that period of time via phone call, text, or email regarding the injury. The student athlete will refrain from participating in practice or competition until they have been cleared to return by the BASD athletic training staff *along with a written clearance for return to play by their attending physician*. This is necessary to reduce the risk of further injury and liability for the LAT staff, coaching staff, and the district.

5. IN PARTICIPATING IN AN AWAY EVENT, IF AN INJURY HAS BEEN DETERMINED TO NOT BE OF A SERIOUS NATURE AND DID NOT REQUIRE IMMEDIATE MEDICAL ATTENTION, you may contact a member of the BASD LAT staff via phone call, text, or email to make arrangements to have the student athlete evaluated in the clinic at Drayer Physical Therapy or in the athletic training room the following day.

6. FAILURE TO REPORT INJURIES DELAYS PROPER REFERRAL to a physician and in providing the necessary follow up, care, and treatment.

7. FAILURE TO REPORT ALSO DELAYS PROPER RETURN of the athlete to participation, delays proper treatment, and inconveniences the athletes and parents.

8. FAILURE TO REPORT ALSO CREATES LIABILITY for the district, its employees, the licensed athletic trainer(s), and the coaching staff.

9. FAILURE TO REPORT HEAD INJURIES sustained by a student athlete in practice or competition, is in direct violation of the SB 200, known as the Safety in Youth Sports Act. This law makes certain requirements of Pennsylvania Schools and the personnel who supervise the student athletes who represent these schools, as well as the medical personnel who support them when there is an injury.

I HEREBY ACKNOWLEDGE AND UNDERSTAND THIS POLICY AND WILL ADHERE TO SHARING IN THE RESPONSIBILITY OF INJURY MANAGEMENT AND PREVENTION FOR OUR STUDENT ATHLETES BY FOLLOWING APPROPRIATE SAFETY PROTOCOLS AND COMMUNICATING AND REPORTING ALL INJURIES TO THE LICENSED ATHLETIC TRAINING STAFF IN A TIMELY AND EFFICIENT MANNER.

_____ _____/_____/_____

Signature of Parent/Guardian Date

_____ _____/_____/_____

Signature of Student Athlete Date

Bellefonte Area School District
Student Athlete Return to Play Requirements

Any Student-Athlete participating and individuals coaching school sponsored activities must adhere to these policies:

1. Student Athletes injured in practice and competitions:
   A. All injuries occurring during Bellefonte sponsored activities, practice, and home and away events should be reported to the Licensed Athletic Trainer(s) at the Bellefonte Area School District.
   B. Failure to report injuries delays proper referral to a physician and in providing the necessary follow up, care, and treatment for the injury. It can also delay the proper return of the athlete to participation, delay proper treatment of the injury or condition, and inconveniences the parents and athletes. Failure to report Head Injuries, sustained by a student-athlete in practice or competition, is in direct violation of SB 200 known as the Safety in Youth Sports Act. This law makes certain requirements of Pennsylvania Schools and the personnel who supervise the student-athletes who represent these schools, as well as the medical personnel who support them when there is an injury.

2. Return to Participation Criteria
   A. Following a complete physical assessment for an injury, the Licensed Athletic Trainer(s) (ATC, LAT) in the Bellefonte Area School District, may, at his or her discretion, return a student-athlete to practice or competition. Return to participation is a progression that will be determined by the ATC, LAT and the attending Physician (If the athlete has been seen by a Licensed Physician for Evaluation and Clearance for the injury). If a student-athlete is not being seen by a licensed physician for a specific injury or pathology, the Bellefonte Area School District Licensed Athletic Trainer(s) will determine when the athlete returns to practice or competition.
   B. Student-Athletes seen by an approved licensed medical professional must secure a written release to return to athletic participation. This is the policy set forth in the Standard Operating Procedures from the Bellefonte Area School District Team Physician.
      a. Approved Licensed Medical Professionals that could return an athlete to activity after being seen for an injury include:
      b. Medical Doctor (MD,DO)- May include any specialist with the credentials MD or DO Dentist (DMD, Podiatrist (DPM)

Pennsylvania Law requires Licensed Athletic Trainers to work under the direction of a Licensed Physician, and therefore must secure a written release from a licensed physician if an athlete has been restricted from participation in athletic and physical activity.

_____ _____

Signature of Parent Date

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 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 then determine whether Section 8 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 or Other Medical Personnel Should be Aware_____

_____

_____

_____

Student's Prescription Medications and conditions of which they are being prescribed _____

_____

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

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Competitive Spirit Squad	
Girls' Gymnastics	
Rifle	
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	
Girls' Lacrosse	
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
Boys' Volleyball	
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 and Bellefonte Area School District'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 District, 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. 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.

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

F. CONFIDENTIALITY: 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).

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 brain injury that:

- Is caused by a bump, blow, or jolt to the head or body.
- 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 tell their Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.
- **The student should be evaluated.** A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.
- **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; and
  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.

_____ _____ Date____/____/_____

Signature of Student-Athlete | Print Student-Athlete's Name

_____ _____ Date____/____/_____

Signature of Parent/Guardian | Print Parent/Guardian's Name

Student's Name _____ Age_____ Grade_____

SECTION 5: 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 been disabled from heart disease or died of heart problems or 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, which caused you to miss a Practice or Contest? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐
Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest 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?	☐	☐

	Yes	No
23. Has a doctor ever 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 ever had a herpes skin infection?	☐	☐
CONCUSSION OR TRAUMATIC BRAIN INJURY		
31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Do you experience dizziness and/or headaches with exercise?	☐	☐
34. Have you ever had a seizure?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you unhappy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
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?	☐	☐

#'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		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

☐ **CLEARED** ☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for:_____

☐ **NOT CLEARED** for the following types of sports (please check those that apply):
☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type) _____ License #_____
Address_____ Phone ( )_____

AME's Signature_____MD, DO, PAC, CRNP, or SNP *(circle one)* Certification Date of CIPPE ___/____/___