

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.

- | | |
|--|--|
| <p>1. Since completion of the CIPPE, have you sustained an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or head injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Since completion of the CIPPE, are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you have any concerns that you would like to discuss with a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|--|

#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 ____/____/____

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 _____

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			Yes	No
1.	Has a doctor ever denied or restricted your participation in sport(s) for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	23.	Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have an ongoing medical condition (like asthma or diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	24.	Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	25.	Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	26.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28.	Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29.	Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30.	Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Has a doctor ever told you that you have (check all that apply):			CONCUSSION OR HEAD INJURY			
	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur			31.	Have you ever had a concussion (i.e. bell rung, ding, head rush) or head injury?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			32.	Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	33.	Do you experience dizziness and/or headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34.	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Has any family member or relative 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"/>
22.	Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY			
				47.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
				48.	How old were you when you had your first menstrual period?	_____	
				49.	How many periods have you had in the last 12 months?	_____	
				50.	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

#s	Explain "Yes" answers here:

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

Student's Signature _____ Date ____/____/____

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

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