

Circle questions you don't know the answers to.

	Yes	No
23. Has a doctor ever told you that you have asthma or allergies?	<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"/>
25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you ever used an inhaler or taken asthma medicine?	<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"/>
28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
30. Have you ever had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>

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?	<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"/>
36.	Have you ever been unable to move your arms or legs after being hit or falling?	<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"/>
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"/>
39.	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
40.	Do you wear glasses or contact lenses?	<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"/>
42.	Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
43.	Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
44.	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
45.	Do you limit or carefully control what you eat?	<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"/>
MENSTRUAL QUESTIONS- IF APPLICABLE		<input type="checkbox"/>	<input type="checkbox"/>
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.	When was your last menstrual period?		

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

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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		<input type="checkbox"/> Heart murmur <input type="checkbox"/> Femoral pulses to exclude aortic coarctation <input type="checkbox"/> 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 ____/____/____