



**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 **May 1<sup>st</sup>** and shall be effective, regardless of when performed during a school year, until the latter of the next **April 30<sup>th</sup>** 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)

Student's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Student's Age on Last Birthday: \_\_\_\_ Grade \_\_\_\_ for 20\_\_\_\_ - 20\_\_\_\_  
School Year

Current Physical Address \_\_\_\_\_

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

Parent/Guardian E-mail Address: \_\_\_\_\_

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](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:** 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 video broadcasts and re-broadcasts, webcasts and 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. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 7 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) occurs when the heart suddenly and unexpectedly stops beating. 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 350,000 cardiac arrests that occur outside of hospitals each year. More than 10,000 individuals under the age of 25 die of SCA each year. SCA is the number one killer of student athletes and the leading cause of death on school campuses.

### Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as

- Dizziness or lightheadedness when exercising;
- Fainting or passing out during or after exercising;
- Shortness of breath or difficulty breathing with exercise, that is not asthma related;
- Racing, skipped beats or fluttering heartbeat (palpitations)
- Fatigue (extreme or recent onset of tiredness)
- Weakness;
- Chest pains/pressure or tightness during or after exercise.

These symptoms can be unclear and confusing in athletes. Some may ignore the signs or think they are normal results off physical exhaustion. If the conditions that cause SCA are diagnosed and treated before a life-threatening event, sudden cardiac death can be prevented in many young athletes.

### What are the risks of practicing or playing after experiencing these symptoms?

There are significant risks associated with continuing to practice or play after experiencing these symptoms. The symptoms might mean something is wrong and the athlete should be checked before returning to play. When the heart stops due to cardiac arrest, 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 experience a SCA die from it; survival rates are below 10%.

### Act 73 – Peyton's Law - Electrocardiogram testing for student athletes

The Act is intended to help keep student-athletes safe while practicing or playing by providing education about SCA and by requiring notification to parents that you can request, at your expense, an electrocardiogram (EKG or ECG) as part of the physical examination to help uncover hidden heart issues that can lead to SCA.

### Why do heart conditions that put youth at risk go undetected?

- Up to 90 percent of underlying heart issues are missed when using only the history and physical exam;
- Most heart conditions that can lead to SCA are not detectable by listening to the heart with a stethoscope during a routine physical; and
- Often, youth don't report or recognize symptoms of a potential heart condition.

### What is an electrocardiogram (EKG or ECG)?

An ECG/EKG is a quick, painless and noninvasive test that measures and records a moment in time of the heart's electrical activity. Small electrode patches are attached to the skin of your chest, arms and legs by a technician. An ECG/EKG provides information about the structure, function, rate and rhythm of the heart.

### Why add an ECG/EKG to the physical examination?

Adding an ECG/EKG to the history and physical exam can suggest further testing or help identify up to two-thirds of heart conditions that can lead to SCA. An ECG/EKG can be ordered by your physician for screening for cardiovascular disease or for a variety of symptoms such as chest pain, palpitations, dizziness, fainting, or family history of heart disease.

- ECG/EKG screenings should be considered every 1-2 years because young hearts grow and change.
- ECG/EKG screenings may increase sensitivity for detection of undiagnosed cardiac disease but may not prevent SCA.
- ECG/EKG screenings with abnormal findings should be evaluated by trained physicians.
- If the ECG/EKG screening has abnormal findings, additional testing may need to be done (with associated cost and risk) before a diagnosis can be made, and may prevent the student from participating in sports for a short period of time until the testing is completed and more specific recommendations can be made.
- The ECG/EKG can have false positive findings, suggesting an abnormality that does not really exist (false positive findings occur less when ECG/EKGs are read by a medical practitioner proficient in ECG/EKG interpretation of children, adolescents and young athletes).
- ECGs/EKGs result in fewer false positives than simply using the current history and physical exam.

**The American College of Cardiology/American Heart Association guidelines do not recommend an ECG or EKG in asymptomatic patients but do support local programs in which ECG or EKG can be applied with high-quality resources.**

#### *Removal from play/return to play*

Any student-athlete who has signs or symptoms of SCA must be removed from play (which includes all athletic activity). The symptoms can happen before, during, or after activity.

Before returning to play, the athlete must be evaluated and cleared. 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 this form and understand the symptoms and warning signs of SCA. I have also read the information about the electrocardiogram testing and how it may help to detect hidden heart issues.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Print Student-Athlete's Name

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

\_\_\_\_\_  
Print Parent/Guardian's Name

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# SECTION 5: 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 ever 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):                                                                                                                                                                                                                                                                                                                                                                                             |                          |                          | <b>CONCUSSION OR TRAUMATIC BRAIN INJURY</b><br>31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? <input type="checkbox"/> <input type="checkbox"/><br>32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> <input type="checkbox"/><br>33. Do you experience dizziness and/or headaches with exercise? <input type="checkbox"/> <input type="checkbox"/><br>34. Have you ever had a seizure? <input type="checkbox"/> <input type="checkbox"/><br>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"/><br>36. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> <input type="checkbox"/><br>37. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> <input type="checkbox"/><br>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"/><br>39. Have you had any problems with your eyes or vision? <input type="checkbox"/> <input type="checkbox"/><br>40. Do you wear glasses or contact lenses? <input type="checkbox"/> <input type="checkbox"/><br>41. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> <input type="checkbox"/><br>42. Are you unhappy with your weight? <input type="checkbox"/> <input type="checkbox"/><br>43. Are you trying to gain or lose weight? <input type="checkbox"/> <input type="checkbox"/><br>44. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> <input type="checkbox"/><br>45. Do you limit or carefully control what you eat? <input type="checkbox"/> <input type="checkbox"/><br>46. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> <input type="checkbox"/><br><b>MENSTRUAL QUESTIONS- IF APPLICABLE</b> <input type="checkbox"/> <input type="checkbox"/><br>47. Have you ever had a menstrual period? <input type="checkbox"/> <input type="checkbox"/><br>48. How old were you when you had your first menstrual period? _____<br>49. How many periods have you had in the last 12 months? _____<br>50. When was your last menstrual period? _____ |                          |                          |              |              |       |            |            |     |       |      |           |       |           |  |  |  |  |  |
| <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur<br><input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection                                                                                                                                                                                                                                                                                        | <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"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                          |              |              |       |            |            |     |       |      |           |       |           |  |  |  |  |  |
| 11. Has anyone in your family died for no apparent reason?                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                          |              |              |       |            |            |     |       |      |           |       |           |  |  |  |  |  |
| 12. Does anyone in your family have a heart problem?                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                          |              |              |       |            |            |     |       |      |           |       |           |  |  |  |  |  |
| 13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                          |              |              |       |            |            |     |       |      |           |       |           |  |  |  |  |  |
| 14. Does anyone in your family have Marfan Syndrome?                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                          |              |              |       |            |            |     |       |      |           |       |           |  |  |  |  |  |
| 15. Have you ever spent the night in a hospital?                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                          |              |              |       |            |            |     |       |      |           |       |           |  |  |  |  |  |
| 16. Have you ever had surgery?                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                          |              |              |       |            |            |     |       |      |           |       |           |  |  |  |  |  |
| 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:<br>18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:<br>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"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                          |              |              |       |            |            |     |       |      |           |       |           |  |  |  |  |  |
| <table border="0"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Upper arm</td> <td>Elbow</td> <td>Forearm</td> <td>Hand/Fingers</td> <td>Chest</td> </tr> <tr> <td>Upper back</td> <td>Lower back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/shin</td> <td>Ankle</td> <td>Foot/Toes</td> </tr> </table>                                                                                                                                  | Head                     | Neck                     | Shoulder                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Upper arm                | Elbow                    | Forearm      | Hand/Fingers | Chest | Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/Toes |  |  |  |  |  |
| 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?                                                                                                                                                                                                                                                                                                                                                                                                                        | <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"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                          |              |              |       |            |            |     |       |      |           |       |           |  |  |  |  |  |
| 22. Do you regularly use a brace or assistive device?                                                                                                                                                                                                                                                                                                                                                                                                           | <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 \_\_\_\_/\_\_\_\_/\_\_\_\_

**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 \_\_\_\_\_ for 20 \_\_\_\_\_ - 20 \_\_\_\_\_  
School Year

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<br><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 \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION 7: 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 8, 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)

Student's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Student's Age on Last Birthday: \_\_\_\_ Grade \_\_\_\_ for 20\_\_\_\_ - 20\_\_\_\_ 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 \_\_\_\_\_

Parent/Guardian E-mail Address: \_\_\_\_\_

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 # ( ) \_\_\_\_\_

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

**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 sustained a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? | <input type="checkbox"/> | <input type="checkbox"/> | 3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | 4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                             |                          |                          | 5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills?                                            | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                             |                          |                          | 6. Do you have any concerns that you would like to discuss with a physician?                                                         | <input type="checkbox"/> | <input type="checkbox"/> |

An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below

| #s | Explain yes answers; include injury, type of treatment & the name of the medical professional seen by student |
|----|---------------------------------------------------------------------------------------------------------------|
|    |                                                                                                               |
|    |                                                                                                               |
|    |                                                                                                               |
|    |                                                                                                               |

**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 8: Re-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 5 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 8 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, who, pursuant to ARTICLE X, LOCAL MANAGEMENT AND CONTROL, Section 2, Powers and Duties of Principal, subsection C, of the PIAA Constitution, shall "exclude any contestant who has suffered serious illness or injury until that contestant is pronounced physically fit by the school's licensed physician of medicine or osteopathic medicine, or if none is employed, by another licensed physician of medicine or osteopathic medicine."

**NOTE:** The physician completing this Form must first review Sections 5 and 6 of the herein named student's previously completed CIPPE Form. Section 7 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 7.

If the physician completing this Form is clearing the herein named student subsequent to that student sustaining a concussion or traumatic brain 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 \_\_\_\_\_ for 20\_\_\_\_ - 20\_\_\_\_  
School Year

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 the date 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 6 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 date 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, in addition to the restrictions, if any, set forth in Section 6 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 \_\_\_\_\_



## Section 9: 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\_\_\_\_ wrestling 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 15<sup>th</sup> 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.