

PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION



INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st or the conclusion of the spring sports season.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 7 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will then determine whether Section 8 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION Student's Name Male/Female (circle one) Date of Student's Birth: ____/___ Age of Student on Last Birthday: ____ Grade for Current School Year: ____ Current Physical Address _____ Current Home Phone # () Parent/Guardian Current Cellular Phone # () Fall Sport(s): ______ Winter Sport(s): _____ Spring Sport(s): _____ **EMERGENCY INFORMATION** Parent's/Guardian's Name______ Relationship _____ Address _____ Emergency Contact Telephone # ()_____ Secondary Emergency Contact Person's Name Relationship Address Emergency Contact Telephone # () Medical Insurance Carrier______ Policy Number_____ Address ______Telephone # () ______ Family Physician's Name______, MD or DO (circle one) Telephone # () Address 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 ___

Revised: March 22, 2017

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 Signature of Parent Winter Signature of Parent Signature of Parent **Sports** or Guardian **Sports** or Guardian **Sports** or Guardian Basketball Baseball Cross Country Bowling Boys' Field Lacrosse Competitive Hockey Girls' Spirit Squad Football <u>Lacro</u>sse Girls' Golf Softball Gymnastics Soccer Bovs' Rifle Tennis Girls' Swimming Track & Field **Tennis** and Diving (Outdoor) Girls' Track & Field Boys' Volleyball (Indoor) Volleyball Water Wrestling Other Polo Polo Other Other Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance. Parent's/Guardian's Signature Disclosure of records needed to determine eligibility: To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data. Parent's/Guardian's Signature _____ Date / / 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 / / Permission to administer emergency medical care: I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student. Parent's/Guardian's Signature Date / **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 quardian(s).

Parent's/Guardian's Signature

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 trauma participating in interscholastic athletics, including the risks associated with continuing to compete traumatic brain injury.			
Student's Signature	_Date	_/	_/
I hereby acknowledge that I am familiar with the nature and risk of concussion and trauma participating in interscholastic athletics, including the risks associated with continuing to compete traumatic brain injury.			
Parent's/Guardian's Signature	_Date		_/

SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

Are there warning signs?

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

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)

- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

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

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it.

Act 59 - the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

Information about SCA symptoms and warning signs.

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may also hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

Removal from play/return to play

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The
 evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart
 doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or
 certified medical professionals.

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

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rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: Head Neck Shoulder Upper Elbow Forearm Hand/ Dack back back back back back back back b								
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#'s Explain "Yes" answers here: last 12 months?	instability?				•	-		
#'s Explain "Yes" answers here: I hereby certify that to the best of my knowledge all of the information herein is true and complete.				last 12 r	months?		_	
I hereby certify that to the best of my knowledge all of the information herein is true and complete.	#'s		E				Ш	
	I hereby certify that to the best of my knowl	edge al	ll of the	information herein i	s true and complete			
Ottudont 3 Oignature		•				1	/	
I hereby certify that to the best of my knowledge all of the information herein is true and complete.								

_Date___/__/

Parent's/Guardian's Signature _____

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____ School Sport(s) Enrolled in 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. Pupils: Equal Unequal Vision: R 20/____ L 20/____ Corrected: YES NO (circle one) MEDICAL NORMAL ABNORMAL FINDINGS Appearance Eyes/Ears/Nose/Throat Hearing Lymph Nodes Heart murmur Femoral pulses to exclude aortic coarctation Cardiovascular 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/quardian 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) License # AME's Name (print/type) Address 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.

	Suppl	LEMENTA	AL HEALT	H HISTORY		
Student's Name				Male/F	emale (c	circle one
Date of Student's Birth://	A	ge of Stud	lent on Las	t Birthday: Grade for Current Scho	ool Year:	
Winter Sport(s):			Spring	Sport(s):		
CHANGES TO PERSONAL INFORMATION (the original Section 1: PERSONAL AND EMERG				fy any changes to the Personal Informat	ion set 1	forth in
Current Home Address						
Current Home Telephone # (F	Parent/Gua	rdian Current Cellular Phone # ()		
CHANGES TO EMERGENCY INFORMATION in the original Section 1: PERSONAL AND EME				tify any changes to the Emergency Info	rmation	set forti
Parent's/Guardian's Name				Relationship		
Address			Emerge	ency Contact Telephone # ()		
Secondary Emergency Contact Person's Nam	e			Relationship		
Address						
Medical Insurance Carrier			_			
Address				I elephone # ()		
Family Physician's Name				, MD	or DO (c	ircle one
Address				Telephone # ()		
SUPPLEMENTAL HEALTH HISTORY:						
Explain "Yes" answers at the bottom of this form Circle questions you don't know the answers to.		No			Yes	No
 Since completion of the CIPPE, have you sustained an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic 	.00		4.	Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?		П
medicine? 2. Since completion of the CIPPE, have you			5.	Since completion of the CIPPE, are you taking any NEW prescription medicines or	_	_
had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?			6.	pills? Do you have any concerns that you would		
 Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? 				like to discuss with a physician?	ш	_
			/// II			
#'s		Explair	n "Yes" an	swers here:		
I hereby certify that to the best of my know	ledge al	II of the in	formation	_	,	,
Student's Signature				Date_	/	_/

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

Date___/__/

Parent's/Guardian's Signature _

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 6 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:	AgeGrade	!
Enrolled in		School
Condition(s) Treated Since Completion of the Herein Named Studen	t's CIPPE Form:	
A. GENERAL CLEARANCE: Absent any illness and/or injury, vidate set forth below, I hereby authorize the above-identified student year in additional interscholastic athletics with no restrictions, exception of the control of the cont	to participate for the remainder of the curre	ent school
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, whic set forth below, I hereby authorize the above-identified student to p in additional interscholastic athletics with, in addition to the restrict CIPPE Form, the following limitations/restrictions:	articipate for the remainder of the current so	hool year
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				_ Schoo
INITIAL ASSESSMENT I hereby certify that I have conducted an Initial Asses and have determined as follows:	ssment of the herein named studen	t consistent with	n the NW	CA OPC
Urine Specific Gravity/Body Weight/	Percentage of Body Fat	MWW		
Assessor's Name (print/type)	As	sessor's I.D. #_		
Assessor's Signature		Date	/	_/
CERTIFICATION Consistent with the instructions set forth above and student is certified to wrestle at the MWW of	during the 20 20	wresting s	season.	
AME's Name (print/type)		License #		
Address	Phon	e ()		
AME's Signature	MD, DO, PAC, CRNP, or SNP (circle one)	Date of Certific	ation/	/

NOTES:

For an appeal of the Initial Assessment, see NOTE 2.

- 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 15th 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.