



Athletic Health

GOVERNOR MIFFLIN ATHLETICS
PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL
EVALUATION (CIPPE)
PARENT / GUARDIAN CONSENT

INSTRUCTIONS

Pennsylvania Interscholastic Athletic Association (PIAA) mandates:

Prior to any student participating in practices, inter-school practices, scrimmages, and/or contests, at any PIAA member school, the student is required to complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE) **performed and signed by an approved medical examiner (licensed physician of medicine, osteopathic medicine, physician's assistant, or nurse practitioner).**

- Parent/guardian needs to fill out the first three sections.
- Parent/guardian needs to sign where indicated on section 2 and 3 and answer all questions.
- Name of insurance is needed on section 2.
- CIPPE must **be performed and signed by an authorized medical examiner. Authorized medical examiners are limited to a licensed physician of medicine or osteopathic medicine, physician's assistant, or certified nurse practitioner.**
- Starting on every June 1st, only one CIPPE is needed per school year and it is valid until May 31st of the following year. For example, a student playing a sport for the 2009-2010 school year needs to have one CIPPE dated on or after June 1, 2009 which would then be good for the entire 2009-2010 school year up until May 31st 2010. Except for fall sports, pre participation physicals must be performed within **six weeks** prior to the start of the season. Physicals performed beyond six weeks will need to be recertified.
- **Recertification**-Athletes playing multiple sports in a school year or who have had their initial CIPPE beyond six weeks to the start of the season, will need to have their original physical recertified for those sports. Parents/guardian will need to complete a **CIPPE recertification form** (Section 5) and turn it in to the Athletic Training Office within six weeks prior to the start of the season. In accordance with PIAA guidelines, the athletic training staff will evaluate and recertify eligible physicals. There will be instances (e.g. injury, illness or change in health status) that the athlete may need to be referred to and recertified by a physician (Section 6).
- Governor Mifflin School District will offer at least one physical for each sport season (fall, winter, spring). If the school physical can not be attended by the athlete, then the athlete, parent/guardian must make their own arrangements for a physical at their expense.

Questions or concerns can be directed to:

Glenn Thompson M.Ed., ATC, CSCS, CES, PES
Heather Bratton M.Ed., ATC, CES, PES
610-775-9456 ext. 6736
Certified Athletic Trainers
Governor Mifflin School District.

GOVERNOR MIFFLIN ATHLETICS
PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION (CIPPE)
PARENT / GUARDIAN CONSENT

The student's parent/guardian must complete all parts of this form

INITIAL EVALUATION: PIAA mandates that starting every June 1st, and prior to any student participating in practices, scrimmages, and/or contests, in the student's *first* sport in a school year, the student is required to undergo a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE) by an authorized medical provider (MD, DO, PA, CRNP). The CIPPE will be valid for the entire school year until May 31st. Except for fall sports, pre participation physicals must be performed within *six weeks* prior to the start of the season. Physicals performed beyond six weeks will need to be recertified. The CIPPE form also must have the parent/guardian complete the first three sections of the CIPPE form. Upon completion of Sections 1, 2, and 3 by the parent/guardian, and Section 4 by an authorized medical provider, the CIPPE form must be turned in to the Certified Athletic Trainer of the student's school for retention by the school.

RECERTIFICATION & SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: A student completing a CIPPE, and seeking to participate in practices, scrimmages, and/or contests in subsequent sport(s) in the same school year, or whose CIPPE was not performed within 6 weeks prior to the start of the season must complete Section 5- CIPPE Recertification Form. The recertification form must be turned in to the Certified Athletic Trainer within six weeks prior to the start of the season. As per PIAA guidelines, The Certified Athletic Trainer, will then determine whether re-examination and recertification will be needed by authorized medical provider (MD, DO, PA, CRNP). (Section 6).

SECTION 1: PERSONAL INFORMATION AND EMERGENCY INFORMATION:

Name _____ Grade _____

Date of Birth _____ Age _____ Sex _____

Current Address _____

Phone H (____) _____ W (____) _____ C (____) _____

Sport _____

Emergency Information

Emergency Contact _____ Relationship _____

Emergency Contact Phone H (____) _____ W (____) _____ C (____) _____

Emergency Contact 2 _____ Relationship _____

Emergency Contact 2 Phone H (____) _____ W (____) _____ C (____) _____

Family Physician _____

Family Physician Address _____

Student's Allergies _____

Student's Health Conditions the Athletic Training Staff, attending physician and medical personnel should be aware _____

Student's Prescription Medications _____

Student's Immunizations (e.g. tetanus/diphtheria, MMR, hepatitis A, B, poliomyelitis, pneumococcal; meningococcal varicella)

Up to date and on file with school _____

Not up to date/ Not on file: Specify _____

SECTION 2: PARENT/GUARDIAN CERTIFICATION, CONSENT AND ACKNOWLEDGEMENT

A: PARENT/ GUARDIAN CERTIFICATION AND CONSENT

I hereby give my consent for _____ born on _____ who turned _____ on his/her last birthday, a student and 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.

Sport	Signature of Parent or Guardian	Date
Baseball (Spring)	_____	_____
Basketball (Winter)	_____	_____
Bowling (Winter)	_____	_____
Cheerleading	_____	_____
Cross Country (Fall)	_____	_____
Field Hockey (Fall)	_____	_____
Football (Fall)	_____	_____
Golf (Fall)	_____	_____
Lacrosse	_____	_____
Soccer	_____	_____
Softball (Spring)	_____	_____
Swimming & Diving	_____	_____
Tennis	_____	_____
Track & Field (Spring)	_____	_____
Volleyball	_____	_____
Water Polo (Fall)	_____	_____
Wrestling (Winter)	_____	_____

B. PARENT ACKNOWLEDGMENT OF RISK, ELIGIBILITY, & PROOF OF INSURANCE

Please indicate Yes (Y)

- | | | |
|--|---|---|
| Y | N | I certify that to the best of my knowledge all of the information herein Sections 1, 2, and 3 is true and complete. |
| Y | N | I grant permission for medical personnel, at their discretion, to release my child's school health record medical information, including information from the health history and physical evaluation, to those individuals deemed necessary by the medical personnel. |
| Y | N | I acknowledge there is a risk of injury associated with athletic competition and that these injuries can be serious and catastrophic such as permanent disability and death. |
| Y | N | I authorize the attending medical personnel e.g. Certified Athletic Trainer, physician, and/or EMS, to respond to and tend to injuries sustained as a result of athletic competition. |
| Y | N | I acknowledge that the PIAA sets eligibility requirements for participation. These requirements include age, amateur status, school attendance, transfer status, academic performance, health and that these requirements are available to me at the high school athletic office. |
| Y | N | I consent to the release to PIAA any requested portion of school records including but not limited to birth and age records, name and residence of parent/guardian or pupil, attendance, grades and academic work. |
| <i>It is school policy that all student athletes are covered in full by medical insurance</i> | | |
| Y | N | I acknowledge that the student is fully covered by medical insurance and I am responsible for expenses incurred as a result of injury while participating in Governor Mifflin Athletics. |

Please indicate the name of your insurance company _____

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

SECTION 3: HEALTH HISTORY: Explain "Yes" answers at the bottom of this form.

Please indicate if the student has had the history of the following

	Yes	No		Yes	No																
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	Y	N	22. Do you regularly use a brace or assistive device ?	Y	N																
2. Do you have an ongoing medical condition (like asthma or diabetes)?	Y	N	23. Has a doctor every told you that you have asthma or allergies?	Y	N																
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	Y	N	24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	Y	N																
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	Y	N	25. Is there anyone in your family who has asthma?	Y	N																
5. Have you ever passed out or nearly passed out DURING exercise?	Y	N	26. Have you ever used an inhaler or taken asthma medicine?	Y	N																
6. Have you ever passed out or nearly passed out AFTER exercise?	Y	N	27. Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	Y	N																
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	Y	N	28. Have you had infectious mononucleosis (mono) within the last month?	Y	N																
8. Does your heart race or skip beats exercise?	Y	N	29. Do you have any rashes, pressure sores, or during other skin problems?	Y	N																
9. Has a doctor ever told you that you have (check all that apply): __High blood pressure __Heart murmur __High cholesterol __Heart infection	Y	N	30. Have you had a herpes skin infection?	Y	N																
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	Y	N	31. Have you ever had a head injury or concussion?	Y	N																
11. Has anyone in your family died for no apparent reason?	Y	N	32. Have you been hit in the head and been confused or lost your memory?	Y	N																
12. Does anyone in your family have a heart problem?	Y	N	33. Have you ever had a seizure?	Y	N																
13. Has any family member or relative died of heart problems or of sudden death before age 50?	Y	N	34. Do you have headaches with exercise?	Y	N																
14. Does anyone in your family have Marfan syndrome?	Y	N	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Y	N																
15. Have you ever spent the night in a hospital?	Y	N	36. Have you ever been unable to move your arms or legs after being hit or failing?	Y	N																
16. Have you ever had surgery?	Y	N	37. When exercising in the heat, do you have severe muscle cramps or become ill?	Y	N																
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or contest? <i>If yes, circle affected area below:</i>	Y	N	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	Y	N																
18. Have you had any broken or fractured bones or dislocated joints? <i>If yes, circle below:</i>	Y	N	39. Have you had any problems with your eyes or vision?	Y	N																
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? <i>If yes, circle below:</i>	Y	N	40. Do you wear glasses or contact lenses?	Y	N																
<table border="1"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Arm</td> <td>Elbow</td> <td>Forearm</td> <td>Hand/Fingers</td> <td></td> </tr> <tr> <td>Chest</td> <td>Upper Back</td> <td>Lower Back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/Shin</td> <td>Foot/toes</td> </tr> </table>	Head	Neck	Shoulder	Arm	Elbow	Forearm	Hand/Fingers		Chest	Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Foot/toes			41. Do you wear protective eyewear, such as goggles or a face shield?	Y	N
Head	Neck	Shoulder	Arm	Elbow	Forearm	Hand/Fingers															
Chest	Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Foot/toes														
								42. Are you happy with your weight?	Y	N											
								43. Are you trying to gain or lose weight?	Y	N											
								44. Has anyone recommended you change your weight or eating habits?	Y	N											
								45. Do you limit or carefully control what you eat?	Y	N											
								46. Do you have any concerns that you would like to discuss with a doctor?	Y	N											
								FEMALES ONLY													
								47. Have you ever had a menstrual period?	Y	N											
								48. How old were you when you had your first menstrual period?		_____											
								49. How many periods have you had in the last 12 months		_____											
								50. Are you pregnant?	Y	N											

Explain "Yes" answers here (indicate question #): _____

I hereby certify that to the best of my knowledge all of the information herein is true and complete I give consent to a physical exam.

Student's Signature _____ Date ____/____/____

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

**SECTION 4: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION
AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER**

Must be completed and signed by an approved medical provider (MD, DO, PA, CRNP) performing the herein named student's comprehensive initial pre-participation physical evaluation and turned in to the Certified Athletic Trainer of the student's school.

Student's Name _____ Age _____ Grade _____
 Enrolled in _____ School _____ Sport(s) _____
 Height _____ Weight _____ Pulse _____ BP _____ / _____ (_____ / _____ , _____ / _____)
 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		
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 and further certify that the student does not have any communicable illness or condition, which would pose a danger to teammates and/or competitors:

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) _____

Authorized Medical Examiner's Name (print/type) License # _____

Address _____ Phone (_____) _____

Authorized Medical Examiner's Signature _____ MD, DO, PA, CRNP (circle one) Date _____ / _____ / _____