April 24, 2013

Dear Parent and Athlete:

The 2013 FALL SPORTS SEASON and the beginning of practice sessions will commence on Monday, August 12, 2013. Sports physicals are scheduled for SATURDAY, JUNE 1, 2013, in the Senior High Gym Lobby. All Senior High and Junior High athletes will be given the physicals on this date.

If you are planning on becoming a candidate for any of the Fall Sports at the Senior High or Junior High, please complete the HASD Athletic Participation Form and the Comprehensive Initial Pre-participation Physical Evaluation (CIPPE) as follows: Sections 1 and 2 are to be completed by the parent/guardian; Sections 3, 4 and 5 by the student and parent/guardian. Section 6 will be completed by the Physician. The completed forms must be presented when you report for your physical exam at the school on June 1. The physical will be good all year for any sport, UNLESS the athlete sustains an injury during the season. There will be no make-up date for school given physicals.

DATE: Saturday, June 1, 2013
PLACE: Senior High School Gym Lobby

Junior High Cheerleading (Grades 7, 8, 9) & Junior High Girls’ Soccer (Grades 7 & 8) 8:00 AM
Senior High Girls’ Soccer & Cross Country (Grades 9, 10, 11, 12) 8:15 AM
Senior High Girls’ Tennis & Golf (Grades 9, 10, 11, 12) 8:30 AM
Senior High Girls’ Volleyball (Grades 10, 11, 12) 8:45 AM
Senior High Cheerleading (Grades 10, 11, 12) 9:00 AM
GIRLS should be completed by 9:30 AM
Senior High Football (Grades 10, 11, 12) 9:30 AM
Senior High Boys’ Cross Country, Golf (Grades 9, 10, 11, 12) 10:00 AM
Senior High Boys’ Soccer (Grades 9, 10, 11, 12) 10:30 AM
Junior High Boys’ Soccer (Grades 7 & 8) 11:00 AM
Junior High Football (Grade 7) 11:20 AM
Junior High Football (Grade 8) 11:40 AM
Junior High Football (Grade 9) 12:00 PM

**NOTE: ALL ATHLETES MUST WEAR SHORTS AND SHORT-SLEEVED SHIRTS FOR PHYSICALS.**

This is the only time Fall Sports Physicals will be given. If you cannot report at the scheduled time, it will be necessary for you to get your physical from your physician at your own expense. Private physicals must not be dated before June 1, 2013 and are due prior to August 12, 2013. Please turn forms in to the Junior High or Senior High Main offices.

If you have any injuries or medical illness concerns, please notify Amy Smearman, Certified Athletic Trainer.

Best Wishes for a Successful Season,

Robert Gildea, Athletic Director
Dear Parent:

We are happy you have decided to allow your son/daughter to play an interscholastic sport here in the Hollidaysburg Area School District. Sports are demanding but offer significant opportunities for him/her to learn valuable lessons. Personal preparation and working to reach goals are among the many valuable lessons to be learned. Hopefully, your son/daughter will have an enjoyable experience.

You should be aware that in all sports there is an element of danger. Injuries do occur, sometimes serious injuries. Please be assured that our coaching staff will watch carefully over the young people they coach to minimize the possibility of injury. Safety is always uppermost in our minds; however, in spite of all precautions, injuries can still occur.

On behalf of the administration and coaching staff, we thank you for your trust and support. We hope it will be a successful season in every way.

Sincerely,

Robert Gildea, Athletic Director
Before students may participate in any sport, it is mandatory that the attached forms be completed and returned to the school nurse or athletic trainer. No coach may accept forms.

Dear Parent/Guardian:

The Pennsylvania Interscholastic Athletic Association (PIAA) mandates that all students participating in interscholastic athletics must have a physical before participating. Please note that the PIAA revised their required physical forms on July 26, 2012. Under the new guidelines of the Comprehensive Initial Pre-participation Physical Evaluation (CIPPE), Sections 1 and 2 are to be completed 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 school nurse or athletic trainer. The CIPPE may not be performed earlier than June 1 and shall be effective, regardless of when performed during the school year, until the next May 31.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR (IF ALREADY TURNED IN CIPPE)

Following completion of a CIPPE, the same student seeking to participate in subsequent sport(s) in the same school year, must complete Sections 1, 2, 3, 4 and 7 of this form and must turn in those Sections to the school nurse or athletic trainer. The school nurse or athletic trainer will then determine whether Section 8 need be completed.

All athletes are covered by an athletic insurance plan paid by the School District. It is a supplement to your family insurance and can only be used if the injury occurred during a school-sponsored practice or game. In cases where the athletic insurance or family insurance does NOT cover the entire cost of the accident, it is the RESPONSIBILITY OF THE PARENT OR GUARDIAN to pick up the additional medical cost. IN NO SITUATION WILL THE SCHOOL DISTRICT PAY ADDITIONAL COSTS NOT COVERED BY THE SCHOOL INSURANCE OR THE FAMILY INSURANCE. IN CASE OF INJURY, IT BECOMES THE RESPONSIBILITY OF THE STUDENT TO OBTAIN AN ATHLETIC INSURANCE CLAIM FORM FROM THE ATHLETIC TRAINER. NEITHER THE PENNSYLVANIA INTERSCHOLASTIC ATHLETIC ASSOCIATION NOR THE HOLLIDAYSBURG AREA SCHOOL DISTRICT ASSUMES RESPONSIBILITY IN THE CASE OF AN ACCIDENT.

Participants in athletic sports are financially responsible for the safe return of all athletic equipment issued to them.

I hereby give my consent for the above-named student to compete in the PIAA approved sport at the Hollidaysburg Area Senior/Junior High School, and for him/her to go with the coach and/or Principal OR HIS/HER AUTHORIZED REPRESENTATIVE on any required trips.

__________________________________________  __________________________________________
DATE                                           PARENT/GUARDIAN SIGNATURE
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 performed earlier than June 1st and shall be effective, regardless of when performed during a school year, until the next May 31st.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 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)

Address __________________________________________ Telephone # ( ___ )___________

Student’s Allergies ______________________________________________________

Student’s Health Condition(s) of Which an Emergency Physician Should be Aware ____________________________

______________________________________________________________

Student’s Prescription Medications __________________________________________

______________________________________________________________

Revised: July 26, 2012
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.

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<thead>
<tr>
<th>Fall Sports</th>
<th>Signature of Parent or Guardian</th>
<th>Winter Sports</th>
<th>Signature of Parent or Guardian</th>
<th>Spring Sports</th>
<th>Signature of Parent or Guardian</th>
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<td>Cross Country</td>
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<td>Softball</td>
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<td>Rifle</td>
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<td>Boys' Tennis</td>
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<td>Girls' Tennis</td>
<td></td>
<td>Swimming and Diving</td>
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<td>Girls' Volleyball</td>
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<tr>
<td>Girls' Volleyball</td>
<td></td>
<td>Track &amp; Field (Indoor)</td>
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<td>Boys' Wrestling</td>
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<tr>
<td>Water Polo</td>
<td></td>
<td>Wrestling</td>
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<td>Other</td>
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<td>Other</td>
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<td>Other</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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, 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: 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 __/__/__

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 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.

Parent's/Guardian's Signature ____________________________________________ Date __/__/__

Revised: July 26, 2012
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 __ / __ / ___

Revised: July 26, 2012
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.

I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete ___________________________ Print Student-Athlete's Name ___________________________ Date ______/_____/______

Signature of Parent/Guardian ___________________________ Print Parent/Guardian’s Name ___________________________ Date ______/_____/______

PA Department of Health: Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form. 7/2012  Revised: July 26, 2012
SECTION 5: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form. Circle questions you don't know the answers to.

Yes No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason? □ □
2. Do you have an ongoing medical condition (like asthma or diabetes)? □ □
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? □ □
4. Do you have allergies to medicines, pollens, foods, or stinging insects? □ □
5. Have you ever passed out or nearly passed out DURING exercise? □ □
6. Have you ever passed out or nearly passed out AFTER exercise? □ □
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? □ □
8. Does your heart race or skip beats during exercise? □ □
9. Has a doctor ever told you that you have (check all that apply):
   □ High blood pressure □ Heart murmur
   □ High cholesterol □ Heart infection
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) □ □
11. Has anyone in your family died for no apparent reason? □ □
12. Does anyone in your family have a heart problem? □ □
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50? □ □
14. Does anyone in your family have Marfan syndrome? □ □
15. Have you ever spent the night in a hospital? □ □
16. Have you ever had surgery? □ □
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. □ □
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below. □ □
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. □ □
20. Have you ever had a stress fracture? □ □
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? □ □
22. Do you regularly use a brace or assistive device? □ □
23. Has a doctor ever told you that you have asthma or allergies? □ □
24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? □ □
25. Is there anyone in your family who has asthma? □ □
26. Have you ever used an inhaler or taken asthma medicine? □ □
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? □ □
28. Have you had infectious mononucleosis (mono) within the last month? □ □
29. Do you have any rashes, pressure sores, or other skin problems? □ □
30. Have you ever had a herpes skin infection? □ □
31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? □ □
32. Have you been hit in the head and been confused or lost your memory? □ □
33. Do you experience dizziness and/or headaches with exercise? □ □
34. Have you ever had a seizure? □ □
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? □ □
36. Have you ever been unable to move your arms or legs after being hit or falling? □ □
37. When exercising in the heat, do you have severe muscle cramps or become ill? □ □
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? □ □
39. Have you had any problems with your eyes or vision? □ □
40. Do you wear glasses or contact lenses? □ □
41. Do you wear protective eyewear, such as goggles or a face shield? □ □
42. Are you unhappy with your weight? □ □
43. Are you trying to gain or lose weight? □ □
44. Has anyone recommended you change your weight or eating habits? □ □
45. Do you limit or carefully control what you eat? □ □
46. Do you have any concerns that you would like to discuss with a doctor? □ □
FEMALES ONLY
47. Have you ever had a menstrual period? □ □
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? □ □

#'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__/__/____

Revised: July 26, 2012
SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student’s comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal’s designee, of the student’s school.

Student’s Name ___________________________________________ Age ______ Grade _______

Enrolled in ___________________________ School ___________________ Sport(s) _______________

Height ______ Weight ______ % Body Fat (optional) _______ Brachial Artery BP ______ / ______ (____ / ____ . ____ / ____ ) RP _______

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student’s primary care physician is recommended.


Vision: R 20/____ L 20/____ Corrected: YES NO (circle one) Pupils: Equal _____ Unequal ______

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
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<tbody>
<tr>
<td>Appearance</td>
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<tr>
<td>Eyes/Ears/Nose/Throat</td>
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<td>Foot/Toes</td>
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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 # ____________________________

AME’s Address __________________________________________ Phone ( ) ____________________________

AME’s License # ____________________________ MD, DO, PAC, CRNP, or SNP (circle one) Date of CIPPE / / 

Revised: July 26, 2012