#435-A
Rev. 7-26-12

MT. LEBANON SCHOOL DISTRICT

Physical Form may be used for Pennsylvania Mandates and Sports Exams

Please attach copy of Immunization Record and Section 5 (Health History)

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 _____ Birth Date_____ Age _____ Grade _____

Enrolled in _____ School Sport(s) _____

Height_____ Weight_____ % Body Fat (optional) _____ Brachial Artery BP_____/_____ (_____/_____ , _____/_____) RP_____

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended. **Age 10-12:** BP:>126/82, RP: >104; **Age 13-15:**BP: >136/86, RP>100; **Age 16-25:** BP: >142/92, RP>96

Vision R 20/_____ L 20/_____ Corrected YES NO (circle one) Pupils: Equal_____ Unequal_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ 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) **Date of CIPPE** (exam)___/____/___

PARENTS MUST COMPLETE AND ATTACH SECTION 5 TO PHYSICAL PAGE FROM PHYSICIAN

Student's Name _____ Age _____ Grade_____

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 died of heart problems or of 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, that 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:	☐	☐
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?	☐	☐
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?	☐	☐

	Yes	No
23. Has a doctor every 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 your 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 had a herpes skin infection?	☐	☐
CONCUSSION OR TRAUMATIC BRAIN INJURY		
31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33.Do you experience dizziness and/or headaches with exercise?	☐	☐
34. Have you ever had a seizure?	☐	☐
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 failing?	☐	☐
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____/____/_____