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Sti	ider	nt'e	Nar	ne

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Age	

## SECTION 3: HEALTH HISTORY

	plain "Yes" answers at the bottom of th			1				
Cir	cle questions you don't know the answ	ers to. Yes	No	]			Yes	No
1.	Has a doctor ever denied or restricted your	105	NO		22.	Do you regularly use a brace or assistive	_	_
	participation in sports for any reason?				23	device? Has a doctor every told you that you have		
2.	Do you have an ongoing medical condition (like asthma or diabetes)?				23.	asthma or allergies?		
3.	Are you currently taking any prescription or				24.	Do you cough, wheeze, or have difficulty		_
	nonprescription (over-the-counter) medicines	I1	F1		25	breathing DURING or AFTER exercise? Is there anyone in your family who has		
4.	or pills?  Do you have allergies to medicines, pollens,				20,	asthma?		
.,	foods, or stinging insects?				26.	Have you ever used an inhaler or taken	_	_
5.	Have you ever passed out or nearly passed	-	<del></del> 1		27	asthma medicine? Were you born without or are your missing a		
6.	out DURING exercise? Have you ever passed out or nearly passed				21.	kidney, an eye, a testicle, or any other organ?		
	out AFTER exercise?				28.	Have you had infectious mononucleosis	<b></b> 1	
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?				29	(mono) within the last month?  Do you have any rashes, pressure sores, or		
8.	Does your heart race or skip beats during	Ш			20.	other skin problems?		
_	exercise?					Have you had a herpes skin infection?		
9.	Has a doctor ever told you that you have (check all that apply):				31.	Have you ever had a head injury or concussion?		
	High blood pressure Heart murmur				32.	Have you been hit in the head and been	_	
	☐ High cholesterol ☐ Heart infection				00	confused or lost your memory?		
10.	Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)					Have you ever had a seizure?  Do you have headaches with exercise?	H	H
11.	Has anyone in your family died for no					Have you ever had numbness, tingling, or		
	apparent reason?					weakness in your arms or legs after being hit	<del>  </del>	
12.	Does anyone in your family have a heart problem?				36	or falling? Have you ever been unable to move your		
13.	Has any family member or relative died of	ш				arms or legs after being hit or failing?		
	heart problems or of sudden death before	_		_	37.	When exercising in the heat, do you have		
1/	age 50?  Does anyone in your family have Marfan				38	severe muscle cramps or become ill? Has a doctor told you that you or someone in		
17.					00,	your family has sickle cell trait or sickle cell		
	15. Have you ever spent the night in a hospital?				00	disease?		
	Have you ever had surgery? Have you ever had an injury, like a sprain,				39.	Have you had any problems with your eyes or vision?	П	
	muscle, or ligament tear, or tendonitis, that				40.	Do you wear glasses or contact lenses?		
	caused you to miss a practice or Contest?				41.	Do you wear protective eyewear, such as goggles or a face shield?		
18	If yes, circle affected area below:  8. Have you had any broken or fractured bones			42.	Are you happy with your weight?	Ë		
	or dislocated joints? If yes, circle below:			43.	Are you trying to gain or lose weight?			
	Have you had a bone or joint injury that				44.	Has anyone recommended you change your weight or eating habits?	· []	
	required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a				45.	Do you limit or carefully control what you eat?		
	cast, or crutches? If yes, circle below:					Do you have any concerns that you would		_
Head	Neck Shoulder Upper Elbow Forearm	Hand/ Fingers	Chest		FEN	like to discuss with a doctor? IALES ONLY	Ш	
Upper back		Ankle	Foot			Have you ever had a menstrual period?		
	Have you ever had a stress fracture?	<u>'                                    </u>			48.	How old were you when you had your first		
	Have you been told that you have or have				40	menstrual period? How many periods have you had in the last	-	
	you had an x-ray for atlantoaxial (neck) instability?		П		٦٥.	12 months?		
	modeliny,	<u></u>				Are you pregnant?		
N	o(s).		Ex	plain "Y	es" a	nswers here:		
		Puntue						·
							2.00	
						·		
	:					,		
l hei	eby certify that to the best of my know	edge al	of the	informa	tion l	nerein is true and complete.		
Stud	lent's Signature					Date	/	
	reby certify that to the best of my knowl	edne all	of the	informa	tion !	perein is true and complete		
		_						·- <del></del>
Pare	nt's/Guardian's Signature		·m			Date_	/	_/

## SECTION 4: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF PHYSICIAN

Must be completed and signed by the licensed physician of medicine or osteopathic medicine performing the herein named student's comprehensive initial pre-participation physical evaluation. Student's Name \_\_\_\_\_ Enrolled in \_\_\_\_\_\_ School Sport(s) \_\_\_\_\_ Height\_\_\_\_\_ Weight\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse\_\_\_\_ BP\_\_\_ / \_\_ ( \_\_ /\_\_\_ , \_\_\_ /\_\_\_) Vision R 20/ L 20/ Corrected YES NO (circle one) Pupils: Equal Unequal NORMAL MEDICAL 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 Recommendation(s)/Referral(s) Physician's Name (print/type) \_\_\_\_ Name (print/type) Physician's Signature\_\_\_\_\_MD or DO (circle one) Date\_\_\_/\_\_\_