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 School Sport(s) Enrolled in 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. Corrected: YES NO (circle one) Pupils: Equal____ Unequal____ Vision: R 20/____ L 20/____ ABNORMAL FINDINGS MEDICAL NORMAL Appearance Eyes/Ears/Nose/Throat Hearing Lymph Nodes Heart murmur Femoral pulses to exclude a rtic 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/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) _ License #___ AME's Name (print/type) ____ Address Address______ Phone ()
AME's Signature______MD, DO, PAC, CRNP, or SNP (circle one) Certification Date of CIPPE ___/__/___