

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 _____ Age _____

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 _____

<input type="checkbox"/> MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
<input type="checkbox"/> 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) _____

Physician's Name (print/type) _____ License # _____

Address _____ Phone (_____) _____

Physician's Signature _____ MD or DO (circle one) Date ____/____/____