

**STATESVILLE CHRISTIAN SCHOOL
COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION**

INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, in the student's first sport in a 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 four Sections of the CIPPE Form. Upon completion of Sections 1,2, and 3 by the parent/guardian, and Section 4 by an Authorized Medical Examiner, 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 shall be performed no earlier than June 1st and shall be effective, regardless of when performed during a school year, until the next May 31.

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 5 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, of the student's school will then determine whether Section 6 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student's Name _____ Age _____ Grade _____

Current Physical Address _____

Current Home Phone # () _____ Parent/Guardian Current Cellular Phone # () _____

EMERGENCY INFORMATION

Primary Emergency Contact Persons 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 _____

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 Statesville Christian School to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the current school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below:

FALL SPORTS	Signature of Parent/Guardian	SPRING SPORTS	Signature of Parent/Guardian
Cross Country		Baseball	
Football		Golf	
Soccer – Boys & MS		Soccer-Girls	
Tennis – Girls		Softball	
Volleyball		Tennis-Boys	
WINTER SPORTS	Signature of Parent/Guardian	OTHER	Signature of Parent/Guardian
Basketball			
Cheerleading			

B. Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of SCS concerning the eligibility of students to participate in Inter-School Practices, Scrimmages, and/or Contests. Such requirements, which are included in the school handbook include, but are not necessarily limited to age, 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: I hereby consent to the release to SCS 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 SCS'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 school, 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: _____

F. Permission to transport student: I consent to SCS arranging transportation to and from Inter-School Practices, Scrimmages, and/or Contests, in either the school's bus or in personal vehicles of the parents or legal guardians of other players or by the coach. I understand that my child will not be permitted to drive to any of the above mentioned activities without special permission and is never permitted to ride in a vehicle to the above mentioned activities with another high school student.

Although the school desires to provide a safe and enjoyable time for all students, accidents can still happen. I/we understand that there are risks/dangers involved with participation in off-campus trips and their associated activities. In consideration of my child being allowed to participate in these events, I/we assume responsibility for those ordinary and reasonable risks associated with the travel and activities. I/we agree to hold harmless Statesville Christian School, its affiliated organizations, employees, agents, and representatives, including volunteer and other drivers, from any and all claims arising from my child's participation. This release agreement does not apply to claims of intentional (criminal) misconduct or gross negligence by the school, its employees, or volunteers. If such circumstances are proved in a court of law, I/we acknowledge and agree that the school can assume no financial liability beyond its actual liability insurance policy in force.

Parent's/Guardian's Signature _____ Date: _____

SECTION 3: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form.

Circle questions you don't know the answers to.

- 1. Has a doctor ever denied or restricted your participation in sport(s) fany reason? Y N
- 2. Do you have an ongoing medical condition (like asthma or diabetes)? Y N
- 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Y N
- 4. Do you have allergies to medicines, pollens, foods, or stinging insects? Y N
- 5. Have you ever passed out or nearly passed out DURING exercise? Y N
- 6. Have you ever passed out or nearly passed out AFTER exercise? Y N
- 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? Y N
- 8. Does your heart race or skip beats during exercise? Y N
- 9. Has a doctor ever told you that you have (check all that apply): Y N
 - High blood pressure
 - Heart murmur
 - High cholesterol
 - Heart infection
- 10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) Y N
- 11. Has anyone in your family died for no apparent reason? Y N
- 12. Does anyone in your family have a heart problem? Y N
- 13. Has any family member or relative died of heart problems or of sudden death before age 50? Y N
- 14. Does anyone in your family have Marfan Syndrome? Y N
- 15. Have you ever spent the night in a hospital? Y N
- 16. Have you ever had surgery? Y N

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? Y N
If yes, circle affected area below:

18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: Y N

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: Y N
 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 stress fracture? Y N

- 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Y N
- 22. Do you regularly use a brace or assistive device? Y N
- 23. Has a doctor every told you that you have asthma or allergies? Y N
- 24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? Y N
- 25. Is there anyone in your family who has asthma? Y N
- 26. Have you ever used an inhaler or taken asthma medicine? Y N
- 27. Were you born without or are your missing a kidney, an eye, a testicle, or any other organ? Y N
- 28. Have you had infectious mononucleosis (mono) within the last month? Y N
- 29. Do you have any rashes, pressure sores, or other skin problems? Y N
- 30. Have you had a herpes skin infection? Y N
- 31. Have you ever had a head injury or concussion? Y N
- 32. Have you been hit in the head and been confused or lost your memory? Y N
- 33. Have you ever had a seizure? Y N
- 34. Do you have headaches with exercise? Y N
- 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Y N
- 36. Have you ever been unable to move your arms or legs after being hit or falling? Y N
- 37. Then exercising in the heat, do you have severe muscle cramps or become ill? Y N
- 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Y N
- 39. Have you had any problems with your eyes or vision? Y N
- 40. Do you wear glasses or contact lenses? Y N
- 41. Do you wear protective eyewear, such as goggles or a face shield? Y N
- 42. Are you unhappy with your weight? Y N
- 43. Are you trying to gain or lose weight? Y N
- 44. Has anyone recommended you change your weight or eating habits? Y N
- 45. Do you limit or carefully control what you eat? Y N
- 46. Do you have any concerns that you would like to discuss with a doctor? Y N
- FEMALES ONLY
- 47. Have you ever had a menstrual period? Y N
- 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? Y N

No(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 _____

**SECTION 4: COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION
AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER**

Must be completed and signed by the Authorized Medical Examiner performing the herein named student's Comprehensive Initial Pre-participation Physical Evaluation and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name _____ Age _____ Grade _____

School Sport(s) _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____ / _____ (_____ / _____, _____ / _____)

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		
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 SCS Comprehensive Initial PreParticipation 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) _____

Authorized Medical Examiner's Name (print/type) _____ License # _____

Address _____ Phone () _____

Authorized Medical Examiner's Signature _____ MD, DO, PAC, CRNP, or SNP (circle one) Date ____/____/____

SECTION 5: STATESVILLE CHRISTIAN RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed by the parent/guardian of any student who (1) completed a Comprehensive Initial PreParticipation Physical Evaluation (CIPPE) between June 1st and participation in the student's first sport season's first Practice of the same school year; and (2) is seeking to participate In Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year. The Principal, or Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY and make a determination as to whether the student should be reevaluated and re-certified by an Authorized Medical Examiner pursuant to Section 6.

SUPPLEMENTAL HEALTH HISTORY

Students Name _____ Age _____ Grade _____

CHANGES TO PERSONAL INFORMATION (In the spaces below, identify any changes to the Personal Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION:

Current Home Address _____

Current Home Telephone # () _____ Parent/Guardian Current Cellular Phone # () _____

CHANGES TO EMERGENCY INFORMATION (In the spaces below, identify any changes to the Emergency Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION:

Primary Emergency Contact Person'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 # _____

SUPPLEMENTAL HEALTH HISTORY:

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

- 1. Have you sustained an illness and/or injury related to sport(s) since completion of the CIPPE? Y N
- 2. Have you sustained an illness and/or injury NOT related to sport(s) since completion or the CIPPE? Y N
- 3. Have you been confined to an institution and/or at home as a result of an illness and/or injury since completion of the CIPPE? Y N
- 4. Have you had surgery since completion of the CIPPE? Y N

- 5. Have you experienced dizzy spells, blackouts, and/or unconsciousness? Y N
- 6. Have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? Y N
- 7. Have you experienced any now health problems since completion of the CIPPE? Y N
- 8. Are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills since completion of the CIPPE? Y N
- 9. Do you have any concerns that you would like to discuss with a doctor? Y N

No(s).	Explain "Yes" answers here:

SUBSEQUENT SPORT(S) TO BE PLAYED: _____ SEASON: Fall Winter Spring (circle one)

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date : _____ Grade _____

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 : _____

NOTE: If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the Principal, or Principal's designee, of the herein named student's school shall require the student to complete Section 6 prior to being eligible to participate in sport(s) identified above.

SECTION 6: STATESVILLE CHRISTIAN COMPREHENSIVE PRE-PARTICIPATION PHYSICAL RE-EVALUATION AND RE-CERTIFICATION BY AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by an Authorized Medical Examiner and turned in to the Principal, or the Principal's designee, of the student's school prior to participation in second and subsequent sport in the same school year.

Student's Name _____ Age _____ Grade _____

Enrolled in Statesville Christian School Sport(s): _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____/_____

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		
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 SUPPLEMENTAL HEALTH HISTORY, performed a physical re-evaluation of the herein named student, and, on the basis of such re-evaluation and the student's SUPPLEMENTAL 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 5 of the PIAA Comprehensive Initial PreParticipation 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) _____

Authorized Medical Examiner's Name (print/type) _____ License _____

Address _____ Phone _____

Authorized Medical Examiner's Signature _____ MD, DO, PAC, CRNP, or SNP (circle one) Date ___/___/___