GENEVA COLLEGE ATHLETIC DEPARTMENT
COMPREHENSIVE INITIAL PRE-PARTICIPATION
PHYSICAL EVALUATION (CIPPE)

INITIAL EVALUATION: Prior to any student participating in Practices, Inter-Squad Practices, Scrimmages, and/or Contests, at any NCAA member school in any 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 all three Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the student-athlete and Section 3 by an Authorized Medical Examiner (AME), those Sections must be submitted to the Director of Athletics or the Athletic Training Department of Geneva College for retention by the college. The CIPPE may not be performed earlier than June 1st and shall be effective, regardless of when performed during a school year, until the next May 31st.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION:

Student-Athlete's Name _____ Male/Female (circle one)

Date of Student's Birth: ____/____/_____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Current Physical Address_____

Current Home Phone # ( )_____ Student-Athlete's Current Cellular Phone # ( )_____

Fall Sport(s): _____ Winter Sport(s): _____ Spring Sport(s): _____

EMERGENCY INFORMATION:

Parent's/Guardian's Name_____ Relationship_____

Address _____Emergency Contact Telephone # ( )_____

Secondary Emergency Contact Person's Name_____ Relationship_____

Address _____Emergency Contact Telephone # ( )_____

Medical Insurance Carrier_____ Policy Number_____

Group Number_____ ID Number_____

Address _____Telephone # ( )_____

Family Physician's Name_____, MD or DO (circle one)

Address _____Telephone # ( )_____

Student's Allergies_____Date of Last Tetanus Shot_____

Student-Athlete's Health Condition(s) of Which an Emergency Physician Should be Aware_____

_____

_____

_____

Student-Athlete's Prescription Medications/Dietary Supplements_____

_____

_____

_____

Glasses/Sport Specs_____ Worn During Competition_____

Contact Lens_____ Hard_____ Soft_____ Extended Wear _____ Worn During Comp._____

Student-Athlete's Name_____ Age_____ Grade_____

SECTION 2: 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 arm	Upper	Elbow	Forearm Fingers	Hand/	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?	[ ]	[ ]

	YES	NO
22. Do you regularly use a brace or assistive device?	[ ]	[ ]
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?	[ ]	[ ]
31. Have you ever had a head injury or concussion?	[ ]	[ ]
32. Have you been hit in the head and been confused or lost your memory?	[ ]	[ ]
33. Have you ever had a seizure?	[ ]	[ ]
34. Do you have headaches with exercise?	[ ]	[ ]
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?		

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-Athlete’s Signature _____ Date_____/____/____

SECTION 3: NCAA 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-athlete's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Director of Athletics or the Athletic Training Department of Geneva College.

Student-Athlete's Name_____ Age _____Grade_____

Enrolled at _____ School Sport(s)_____

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

If either the blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended. **Age 18-25:** 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		
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-athlete, and, on the basis of such evaluation and the student-athlete's HEALTH HISTORY, certify that, except as specified below, the student-athlete is physically fit to participate in Practices, Inter-Squad Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student-athlete in Section 2 of the NCAA 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 ___/____/___