



**BETHLEHEM**  
AREA SCHOOL DISTRICT  
FREEDOM / LIBERTY ATHLETICS

**To: Student-Athletes and Parents/Guardians of Student-Athletes**  
**From: Freedom and Liberty Athletic Departments**  
**Re: PIAA/BASD Athletic Physicals for the 2026-27 School Year**

The Bethlehem Area School District (BASD) is transitioning to a new online platform for PIAA Athletic Physicals. Student-athletes and parents/guardians will receive updated instructions via the school district's website, through Freedom and Liberty High Schools and on social media in the coming weeks about how to complete the physical forms through Arbiter Student Registration when the new online platform is ready for use.

Student-athletes may still get physicals for the 2026-27 school year beginning on May 1, 2026. Student-athletes should take Sections 5/6 of the PIAA packet (see attached) to their healthcare provider, then keep the signed forms until updated instructions become available.

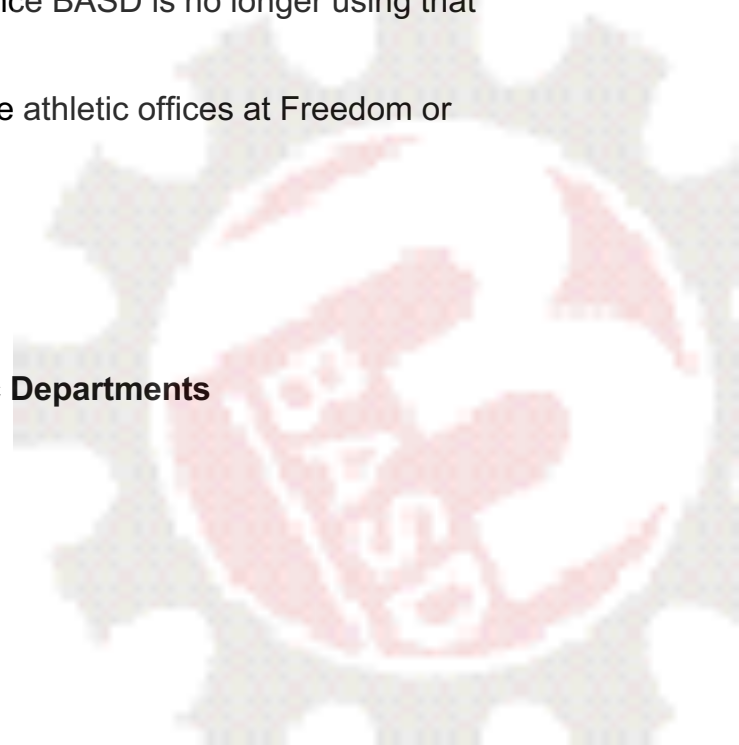
BASD, in conjunction with St. Luke's, will offer free physicals for the 2026-27 school year in the coming weeks. Freedom High School will host a physical clinic on May 27; Liberty High School will host on June 2. Further details will be included when updated instructions are provided.

Please do not complete the electronic physical forms in Big Teams/Student Central (as you have done in past years), since BASD is no longer using that platform.

If you have any questions, please contact the athletic offices at Freedom or Liberty High School.

Thank you for your attention.

**Freedom and Liberty High School Athletic Departments**



**SECTION 5: 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?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like asthma or diabetes)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply):   |                          |                          |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Heart murmur   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High cholesterol   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Heart infection  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan Syndrome?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:      | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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: | <input type="checkbox"/> | <input type="checkbox"/> |
- |            |            |          |           |       |           |                  |               |
|------------|------------|----------|-----------|-------|-----------|------------------|---------------|
| Head       | Neck       | Shoulder | Upper arm | Elbow | Forearm   | Hand/<br>Fingers | Chest         |
| Upper back | Lower back | Hip      | Thigh     | Knee  | Calf/shin | Ankle            | Foot/<br>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?
22. Do you regularly use a brace or assistive device?

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
| 23. Has a doctor ever told you that you have asthma or allergies?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Is there anyone in your family who has asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you ever had a herpes skin infection?   | <input type="checkbox"/> | <input type="checkbox"/> |

**CONCUSSION OR TRAUMATIC BRAIN INJURY**

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
| 31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?            | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Do you experience dizziness and/or headaches with exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear protective eyewear, such as goggles or a face shield?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you unhappy with your weight?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns that you would like to discuss with a doctor?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
- MENSTRUAL QUESTIONS- IF APPLICABLE**
- |  |                          |                          |
|--|--------------------------|--------------------------|
| 47. Have you ever had a menstrual period?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. When was your last menstrual period?                       |                          | _____                    |

#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 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 \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Enrolled in \_\_\_\_\_ School Sport(s) \_\_\_\_\_

Height'--\_\_ Weight\_\_ % Body Fat (optional) \_\_ Brachial Artery BP\_\_ /\_\_ ( \_\_ } \_\_ , \_\_ /\_\_ J 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.

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		<input type="checkbox"/>
Cardiovascular		Heart murmur <b>D</b> Femoral pulses to exclude aortic coarctation <input type="checkbox"/> 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/High		
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:

**D CLEARED** **D CLEARED** with recommendation(s) for further evaluation or treatment for: \_\_\_\_\_

**D 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) Certification Date of CIPPE \_/ \_/ \_