

WEST PERRY SCHOOL DISTRICT

2018-19
ATHLETIC PARTICIPATION BOOKLET
PHYSICAL DATE:

STUDENT NAME: _____ GRADE: _____

SPORT: (CIRCLE ALL SPORTS YOU INTEND TO PARTICIPATE IN)

FALL

WINTER

SPRING

CHEERLEADING

BASKETBALL

BASEBALL

CROSS COUNTRY

CHEERLEADING

SOFTBALL

FIELD HOCKEY

WRESTLING

TRACK & FIELD

FOOTBALL

VOLLEYBALL (GIRLS 7-9)

SOCCER (B&G 9-12)

SOCCER (B&G 7-8)

VOLLEYBALL (GIRLS 10-12)

COMPLETING THIS PACKET...

THIS PACKET MUST BE COMPLETED BEFORE A STUDENT MAY PARTICIPATE IN ANY ATHLETIC PROGRAM AT WEST PERRY.

COMPLETE ALL INFORMATION AS REQUESTED. INCOMPLETE FORMS MAY BE REJECTED.

1. Read Introduction, Acknowledgement of Risk and Consent to Participate and Code of Conduct for Athletes
2. Complete Academic Eligibility History, Sport Participation History and Proof of Insurance
3. Complete PIAA CIPPE Section 1: Personal and Emergency Information
4. Complete and sign PIAA CIPPE Section 2: Certification of Parent/Guardian
5. Read and sign PIAA CIPPE Section 3: Understanding of Risk of Concussion and Traumatic Brain Injury
6. Read and sign PIAA CIPPE Section 4: Understanding of Sudden Cardiac Arrest Symptoms and Warning Signs
7. Complete and sign PIAA CIPPE Section 5: Health History
8. An Authorized Medical Examiner must complete and sign PIAA CIPPE Section 6

Dear Parent & Student Athlete:

This booklet was developed to make the task of completing preseason paperwork easier for you. As you read through this information please make sure that you fully complete each page and provide all the required information.

Please keep in mind that a student must receive a physical before they may participate in sports for each school year. **After completion of an initial physical of each school year the student and parent/guardian will need to complete only Section 7: PIAA Re-Certification by Parent/Guardian before the student may participate in subsequent sports. Wrestlers must complete Section: 9 CIPPE Minimum Wrestling Weight Classification no earlier than six weeks prior to the first Practice Day of the winter sports season.** The District provides an opportunity for each student to receive a physical at the high school facility. This is done in cooperation with the Family Practice Center of Loysville. This booklet must be completed prior to and submitted on the day of the physical and be accompanied by a check or money order made out to Family Practice Center of Loysville in the amount of **\$25.00**. If a student receives a physical at a location other than the school he/she must submit this booklet to the coach prior to the first day of practice. **No student will be permitted to participate in a sport until this booklet is properly completed and on file with the District.**

Regulations pertaining to the athlete are included in the student handbook. Should you have any questions please contact the office of the Director of Athletics at 789-3934 Ext. 5415.

ACKNOWLEDGEMENT OF RISK AND CONSENT TO PARTICIPATE

We, the parent/guardian of the student named on the cover of this booklet and by our signature acknowledge an awareness that participation in athletics; cheerleading, cross country, field hockey, football, soccer, volleyball, basketball, wrestling, baseball, softball, and track & field, involves a risk of injury. I understand that this risk includes severe injuries involving possible paralysis, permanent mental disability, or death, and that these injuries may occur in some instance as the result of unavoidable accidents.

We, the parent/guardian, by our signature on final page of this booklet indicate our acceptance of these risks and give consent for participation in the named sport activities for our son/daughter for this school year.

CODE OF CONDUCT FOR ATHLETES

The conduct of an athlete is closely observed in many areas of life. It is important that your behavior be above reproach in all of the following areas:

ON THE FIELD/COURT/MAT - In the area of athletic competition, a real athlete does not use profanity or illegal tactics, and learns fast that losing is part of the game and that you should be gracious in defeat and modest in victory. It is always courteous to congratulate the opponent on a well played game after the contest, whether in defeat or victory.

IN THE CLASSROOM - In the academic area, a good athlete becomes a good student. A person cannot be a classroom laggard and think he/she can be an outstanding athlete. If you are lazy in class, you will be lazy on the practice field, court or mat, and will never reach your full potential. As an athlete, you must plan your schedule so that you give sufficient time and energy to your studies to insure acceptable grades.

In addition to maintaining good scholarship, an athlete should give respectful attention to classroom activities and show respect for other students and faculty at all times. Horse play and unnecessary boisterousness are not approved habits of behavior.

A healthy athlete should have a good attendance record. Never cut classes or school.

IN SCHOOL AND IN THE COMMUNITY - The way we act and look are important. Athletes should be leaders. Fellow students should respect and follow the good examples set by the athletes. Your dress, language, and actions should reflect the conduct expected of you by the District and coaching staff.

Name _____
(First) (Last)

ACADEMIC ELIGIBILITY HISTORY

Number of years you attended each grade, including this school year.

7-___ 8-___ 9-___ 10-___ 11-___ 12-___

SPORT PARTICIPATION HISTORY

List the number of years you participated in each sport in each grade including this school year. **INCLUDE PARTICIPATION IN SCHOOL PROGRAMS ONLY.** Do not include community or youth group participation.

FALL	_____	-	7-___	8-___	9-___	10-___	11-___	12-___
	<small>(SPORT)</small>							
	_____	-	7-___	8-___	9-___	10-___	11-___	12-___
	<small>(SPORT)</small>							
WINTER	_____	-	7-___	8-___	9-___	10-___	11-___	12-___
	<small>(SPORT)</small>							
	_____	-	7-___	8-___	9-___	10-___	11-___	12-___
	<small>(SPORT)</small>							
SPRING	_____	-	7-___	8-___	9-___	10-___	11-___	12-___
	<small>(SPORT)</small>							
	_____	-	7-___	8-___	9-___	10-___	11-___	12-___
	<small>(SPORT)</small>							

PROOF OF INSURANCE

It is the policy of the West Perry School District that any student participating in athletics: baseball, basketball, cheerleading, cross country, field hockey, junior high football*, soccer, softball, track & field, volleyball, and/or wrestling must have accident insurance. (*HIGH SCHOOL FOOTBALL IS NOT COVERED BY SCHOOL INSURANCE) This insurance can be provided through your place of employment, your own individual contract or through the school carrier. If insurance is not provided by the parent/guardian the student may not participate in interscholastic athletics.

Please indicate below which coverage you have for your son/daughter.

[] YES - we have purchased school insurance for our child.

[] YES - our child is covered.

BY SIGNING THIS BOOKLET THE PARENT/GUARDIAN ASSUMES THE FULL RESPONSIBILITY OF PAYING FOR ANY ATHLETIC INJURY THAT OCCURS TO HIS/HER SON/DAUGHTER THROUGH HIS/HER INSURANCE OR HOSPITAL PLAN. THE SCHOOL WILL NOT BE RESPONSIBLE FOR ANY ATHLETIC INJURY.

PARENT/STUDENT SIGNATURE FORM

My signature indicates that I have read, understand, and agree with the contents of this booklet and that I have provided all the requested information. It also indicates that the named student has permission to participate in each of the sports listed and that we understand and assume full responsibility for the risks involved and injuries that may occur from this participation.

I hereby acknowledge that I am familiar with the requirements of P.I.A.A. concerning the eligibility of students of P.I.A.A. member schools to participate in interscholastic athletic contests involving P.I.A.A. member schools. Such requirements include, but are not limited to: age, amateur status, school attendance, health, transfer from one school to another, semesters of attendance, seasons of sports participation, and academic performance. I hereby consent to the release to P.I.A.A. of any portion of school record files, beginning with the seventh grade, of my child that is necessary to enable P.I.A.A. to determine whether the student is eligible to participate in interscholastic athletics involving P.I.A.A. member schools, specifically including. Without limiting the generality of the foregoing, birth and age records, name and residence address of parent or guardian, residence address of pupil, academic work completed, grades received and attendance data.

FALL

(SPORT)

(SPORT)

WINTER

(SPORT)

(SPORT)

SPRING

(SPORT)

(SPORT)

PARENT SIGNATURE: _____ DATE: ____/____/____

STUDENT SIGNATURE: _____ DATE: ____/____/____



**PIAA COMPREHENSIVE INITIAL
PRE-PARTICIPATION PHYSICAL EVALUATION**



INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA 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 the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), 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 may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st or the conclusion of the spring sports season.

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 7 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, will then determine whether Section 8 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student'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 # () _____ Parent/Guardian 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 _____

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 or Other Medical Personnel Should be Aware _____

Student's Prescription Medications and conditions of which they are being prescribed _____

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 _____ School and a resident of the _____ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____ - 20____ 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 or Guardian
Cross Country	
Field Hockey	
Football	
Golf	
Soccer	
Girls' Tennis	
Girls' Volleyball	
Water Polo	
Other	

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Competitive Spirit Squad	
Girls' Gymnastics	
Rifle	
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	
Girls' Lacrosse	
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
Boys' Volleyball	
Other	

B. **Understanding of eligibility rules:** I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, 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:** To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA 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 PIAA's use of the herein named student's name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, 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. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student.

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

F. **CONFIDENTIALITY:** The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school's athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).

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

SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body.
- Can change the way a student's brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been "dinged" or "had their bell rung."

All concussions are serious. A concussion can affect a student's ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student's brain time to heal.

What are the symptoms of a concussion?

Concussions cannot be seen; however, in a potentially concussed student, **one or more** of the symptoms listed below may become apparent and/or that the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should students do if they believe that they or someone else may have a concussion?

- **Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.
- **The student should be evaluated.** A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.
- **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

How can students prevent a concussion? Every sport is different, but there are steps students can take to protect themselves.

- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:
 - The right equipment for the sport, position, or activity;
 - Worn correctly and the correct size and fit; and
 - Used every time the student Practices and/or competes.
- Follow the Coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If a student believes they may have a concussion: Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student's Signature _____ Date ____/____/____

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

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

SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it.

Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

Information about SCA symptoms and warning signs.

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may *also* hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

Removal from play/return to play

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA.

_____ Signature of Student-Athlete	_____ Print Student-Athlete's Name	Date ____/____/____
_____ Signature of Parent/Guardian	_____ Print Parent/Guardian's Name	Date ____/____/____

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/Fingers Chest | | |
| Upper back Lower back Hip Thigh Knee Calf/shin | | |
| 20. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|--|--------------------------|--------------------------|
| | 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"/> |

FEMALES ONLY

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. How many periods have you had in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

#'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 _____ / _____ (_____ / _____ , _____ / _____) 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		
Cardiovascular		<input type="checkbox"/> Heart murmur <input type="checkbox"/> 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/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) _____

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

Address _____ Phone (_____) _____

AME's Signature _____ MD, DO, PAC, CRNP, or SNP (circle one) Certification Date of CIPPE ____/____/____

SECTION 7: RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal, or the Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY.

If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the herein named student shall submit a completed Section 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

SUPPLEMENTAL HEALTH HISTORY

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

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

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

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):

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 _____

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.

- | | |
|--|--|
| <p>1. Since completion of the CIPPE, have you sustained an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>6. Do you have any concerns that you would like to discuss with a physician? Yes <input type="checkbox"/> No <input type="checkbox"/></p> |
|--|--|

#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 8: Re-CERTIFICATION BY LICENSED PHYSICIAN OF MEDICINE OR OSTEOPATHIC MEDICINE

This Form must be completed for any student who, subsequent to completion of Sections 1 through 6 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 8 may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to the Principal, or the Principal's designee, of the student's school, who, pursuant to ARTICLE X, LOCAL MANAGEMENT AND CONTROL, Section 2, Powers and Duties of Principal, subsection C, of the PIAA Constitution, shall "exclude any contestant who has suffered serious illness or injury until that contestant is pronounced physically fit by the school's licensed physician of medicine or osteopathic medicine, or if none is employed, by another licensed physician of medicine or osteopathic medicine."

NOTE: The physician completing this Form must first review Sections 5 and 6 of the herein named student's previously completed CIPPE Form. Section 7 must also be reviewed if both (1) this Form is being used by the herein named student to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in a subsequent sport season in the same school year AND (2) the herein named student either checked yes or circled any Supplemental Health History questions in Section 7.

If the physician completing this Form is clearing the herein named student subsequent to that student sustaining a concussion or traumatic brain injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.

Student's Name: _____ Age _____ Grade _____

Enrolled in _____ School _____

Condition(s) Treated Since Completion of the Herein Named Student's CIPPE Form: _____

A. GENERAL CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with no restrictions, except those, if any, set forth in Section 6 of that student's CIPPE Form.

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

Address _____ Phone () _____

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

B. LIMITED CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with, in addition to the restrictions, if any, set forth in Section 6 of that student's CIPPE Form, the following limitations/restrictions:

1. _____
2. _____
3. _____
4. _____

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

Address _____ Phone () _____

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

Section 9: CIPPE MINIMUM WRESTLING WEIGHT

INSTRUCTIONS

Pursuant to the Weight Control Program adopted by PIAA, prior to the participation by any student in interscholastic wrestling, the Minimum Wrestling Weight (MWW) at which the student may wrestle during the season must be (1) certified to by an Authorized Medical Examiner (AME) and (2) established NO EARLIER THAN six weeks prior to the first Regular Season Contest day of the wrestling season and NO LATER THAN the Monday preceding the first Regular Season Contest day of the wrestling season (See NOTE 1). This certification shall be provided to and maintained by the student's Principal, or the Principal's designee.

In certifying to the MWW, the AME shall first make a determination of the student's Urine Specific Gravity/Body Weight and Percentage of Body Fat, or shall be given that information from a person authorized to make such an assessment ("the Assessor"). This determination shall be made consistent with National Federation of State High School Associations (NFHS) Wrestling Rule 1, Competition, Section 3, Weight-Control Program, which requires, in relevant part, hydration testing with a specific gravity not greater than 1.025, and an immediately following body fat assessment, as determined by the National Wrestling Coaches Association (NWCA) Optimal Performance Calculator (OPC) (together, the "Initial Assessment").

Where the Initial Assessment establishes a percentage of body fat below 7% for a male or 12% for a female, the student must obtain an AME's consent to participate.

For all wrestlers, the MWW must be certified to by an AME.

Student's Name _____ Age _____ Grade _____
Enrolled in _____ School _____

INITIAL ASSESSMENT

I hereby certify that I have conducted an Initial Assessment of the herein named student consistent with the NWCA OPC, and have determined as follows:

Urine Specific Gravity/Body Weight _____ / _____ Percentage of Body Fat _____ MWW _____

Assessor's Name (print/type) _____ Assessor's I.D. # _____

Assessor's Signature _____ Date ____ / ____ / ____

CERTIFICATION

Consistent with the instructions set forth above and the Initial Assessment, I have determined that the herein named student is certified to wrestle at the MWW of _____ during the 20____ - 20____ wrestling season.

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

Address _____ Phone () _____

AME's Signature _____ MD, DO, PAC, CRNP, or SNP Date of Certification ____ / ____ / ____
(circle one)

For an appeal of the Initial Assessment, see NOTE 2.

NOTES:

1. For senior high school wrestlers coming out for the Team AFTER the Monday preceding the first Regular Season Contest day of the wrestling season the OPC will remain open until January 15th and for junior high/middle school wrestlers coming out for the Team AFTER the Monday preceding the first Regular Season Contest day of the wrestling season the OPC will remain open all season.
2. Any athlete who disagrees with the Initial Assessment may appeal the assessment results one time by having a second assessment, which shall be performed prior to the athlete's first Regular Season wrestling Contest and shall be consistent with the athlete's weight loss (descent) plan. Pursuant to the foregoing, results obtained at the second assessment shall supersede the Initial Assessment; therefore, no further appeal by any party shall be permitted. The second assessment shall utilize either Air Displacement Plethysmography (Bod Pod) or Hydrostatic Weighing testing to determine body fat percentage. The urine specific gravity testing shall be conducted and the athlete must obtain a result of less than or equal to 1.025 in order for the second assessment to proceed. All costs incurred in the second assessment shall be the responsibility of those appealing the Initial Assessment.