

Athletic Department
ELIZABETHTOWN AREA HIGH SCHOOL

TO: Student-Athletes, Parents and/or Guardians

FROM: Shane Piper, M.Ed., R.A.A.
Athletic Director

RE: Athletic Physicals for Fall, Winter and/or Spring

Please complete the attached packet for interested students-athletes who have intentions of participating in the Elizabethtown Area School District interscholastic athletic programs. All appropriate papers must be completed in their entirety prior to a student-athlete being allowed to practice or participate in a contest. In addition, an annual **\$20.00 processing fee must accompany the physical forms.** *** (check or money order may be made payable to the Elizabethtown Area School District)* ***It is mandated by the P.I.A.A. and the EASD that all physicals be completed after June 1, of the current school year, and will only be valid until the end of the current school year.**

FOR NEW ATHLETES (student-athlete has not participated in an interscholastic activity during the current school year). ***\$20.00 processing fee must accompany completed forms**

YELLOW (*Acknowledgment of Risk Form, Athletic Responsibility Acknowledgment Form, Code of Conduct for Parent/Guardians, and Elizabethtown Area School District Drug & Alcohol Policy Form*), **GREEN** (*sections 1, 2 & 3*) (*Parent completes*)
ORANGE (*section 4*) (*Physician completes*)

FOR ATHLETES WHO HAVE PARTICIPATED ON AN INTERSCHOLASTIC ATHLETIC TEAM (student-athlete has participated on an interscholastic athletic team, for the current school year, and were able to answer **NO** to every question under SUPPLEMENTAL HEALTH HISTORY on Section 5: Re-Certification by Parent Guardian.) *****Only to be completed upon the completion of the previous sport season during current school year.**

PINK (*section 5*) (*Parent completes*)

FOR ATHLETES WHO HAVE PARTICIPATED ON AN INTERSCHOLASTIC TEAM AND RECEIVED AN INJURY OR CHANGE IN MEDICAL CONDITION (student-athlete participated on an interscholastic athletic team, for the current school year, and answered **YES** to any question under SUPPLEMENTAL HEALTH HISTORY on Section 5: Re-Certification by Parent Guardian.) *****Only to be completed upon the completion of the previous sport season during current school year.**

***CONTACT THE ATHLETIC OFFICE FOR THE FORM.**

WHITE (*section 6*) (*Physician completes*)

Sections 1, 2, 3, 4 (NEW PHYSICALS ONLY) an/ord Sections 5 or 6 should be returned to the Athletic Office no later than Monday, August 3, 2009 (fall), Monday, November 9, 2009 (winter), or Monday, February 22, 2010 (spring).

ACKNOWLEDGMENT OF RISK FORM

ATHLETE'S NAME _____ **YEAR** _____

SPORT _____ **DATE OF BIRTH** _____ **AGE** _____

Circle the grades you have completed in this sport including the present season: 7 8 9 10 11 12

Number of Semesters of Attendance in School – including this present semester:
(For a grade you have already completed, you should put a 2 on the line, for your current grade, you should put a 1 on the line if you are completing in a fall or winter sport, or a 2 if you are competing in a spring sport).

7 _____ 8 _____ 9 _____ 10 _____ 11 _____ 12 _____

PIAA By-Laws Article IV – Section 1

A pupil shall be eligible for practice or participation in each sport only when there is on file with the principal, a Certificate of Consent which is signed by his/her parent or guardian. I (parent/guardian) acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA members' schools to participate in interscholastic athletic contests involving PIAA member schools. Such requirements include, but are not necessarily limited to: age, amateur statues, school attendance, health, transfer from one school to another, semesters or attendance, seasons of sports participation, and academic performance.

Parent's Certificate

I hereby consent to the release by the Elizabethtown Area School District to PIAA of any portion of the school record file of the student necessary to enable PIAA to determine whether the above named pupil is eligible to participate in interscholastic athletics involving PIAA member schools, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent or guardian, residence of pupil, academic work completed, grades received, and attendance data.

In accordance with the PIAA By-Laws, Article IV, Section 1, I give my consent for the above named student, a pupil of the Elizabethtown Area School District, to take part in the athletic contests during the school year 20 ____ - 20 ____ in the sport listed above as indicated by my signature.

Assumption of Risk

I understand there are dangers involved with sports participation and are aware that participating in athletics can result in severe injury or even death from a variety of circumstances, which include, but are not limited to, falls, collisions with other athletes or equipment, and/or weather conditions. I understand that athletic participation can be inherently dangerous and understand and assume the risks involved.

STUDENT ATHLETE SIGNATURE _____ **DATE** _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

ATHLETIC RESPONSIBILITY ACKNOWLEDGEMENT FORM

ATHLETE'S NAME _____ **YEAR** _____

SPORT _____ **COACH** _____

**PRIOR TO PARTICIPATING IN ANY PRACTICE OR TRYOUT SESSIONS
FOR ANY INTERSCHOLASTIC SPORT EACH ATHLETE MUST:**

Successfully pass a physical examination by a registered physician and the copy of such examination must be on file in the Athletic Office. One current physical examination per year is sufficient for all sports during that school year.

**AS AN ELIZABETHTOWN AREA SCHOOL DISTRICT ATHLETE PARTICIPATING VOLUNTARILY
IN INTERSCHOLASTIC ATHLETICS, I UNDERSTAND THAT:**

1. I understand that participating in Elizabethtown Area Interscholastic Athletics is a privilege, not a right. I will abide by the Elizabethtown Area School District Student Code of Conduct, the head coaches' team rules, and the rules of the P.I.A.A. to ensure the right of participation.
2. I will be responsible for all athletic equipment issued to me throughout the season, and will return such equipment at the conclusions of the season, and will pay the current replacement cost for any of the equipment not accounted for by me at the end of the season. I will not wear school uniforms except at meets/games/contests or as directed by my coach. I understand that I will not be permitted to participate in another athletic season until I return my issued equipment or pay for a replacement.
4. I will not use or be in possession of tobacco, alcohol or narcotics (including steroids). If I do use any of these substances, am in possession of such substances, or am suspended from school for use or possession of these substances, I will be subject to disciplinary actions as outlined in the School District's Policy regarding substance abuse and Athletic Training Rules
5. I acknowledge that I have been properly advised, cautioned and warned by administrative and coaching personnel of the EASD that I am exposing myself to risk of injury, including but not limited to, the risk of sprains, fractures and ligament and cartilage damage which could result in a temporary or permanent, partial or complete impairment in the use of my limbs, brain damage, paralysis; or even death. Having been so cautioned and warned, it is still my desire to participate in sports and to do so with full knowledge and understanding of the risk of injury.
6. I understand that if I am not passing the minimum number of credits per week (three for the Senior High and four for the Junior High) for the week in question, I will be ineligible to play in contests/meets/games from the following Saturday through the next following Sunday (students may practice, but may not dress or travel to away games). At report card time, if a student is failing three or more daily subjects, the student will be ineligible to compete for the first fifteen days of the next marking period.
7. I have had an opportunity to read the *Handbook for Student-Athletes and Parents of Student-Athletes*. I understand that the *Handbook for Student-Athletes and Parents and Student-Athletes* explains the policies and procedures for the Elizabethtown Area Interscholastic Athletic Programs.

STUDENT ATHLETE SIGNATURE _____ **DATE** _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

**Code of Conduct for
Parent/Guardians**

1. Do not force your child to participate in sports, but support their desire to play their chosen sport. Children are involved in organized sports for their enjoyment. Make it fun!
2. Encourage your child to play by the rules. Remember, children learn best by example, so applaud the good plays of both teams.
3. Do not embarrass your child by yelling at players, coaches or officials. By showing a positive attitude toward the game and all of its participants, your child will benefit.
4. Emphasize skill development and practices and how they benefit your child.
5. Know and study the rules of the game, and support the officials on and off the playing field.
6. Applaud a good effort in both victory and defeat, and enforce the positive points of the game. Never yell or physically abuse your child during or after a game or practice.
7. Recognize the importance of volunteer coaches. They are important to the development of your child and the sport. Communicate with them and support them
8. Never argue with an official's decision.
9. Never strike, attempt to strike or otherwise physically abuse an official, opposing player, spectator or coach.
10. Do not intentionally engage in or incite participants and/or spectators to engage in abusive or violent acts.
11. Do not use obscene gestures, profanity or disrespectful language.
12. Understand and follow all rules of the game and the PIAA regulations.
13. Do not smoke or use drug or alcohol on school property.

Signature of parent/guardian

Date

Signature of parent/guardian

Date

Signature of coach/athletic personnel

Date

Signature of Athletic Director/Principal

Date

The EASD Athletic Department would like to thank the parents in advance for their cooperation and understanding.

ELIZABETHTOWN AREA SCHOOL DISTRICT DRUG & ALCOHOL POLICY

1. Any student-athlete violating the District Drug and Alcohol Policy out of school, in school or at a school-related activity will be in violation of school district and athletic department policies and procedures and will be subject to the following consequences:

*In addition, the student-athlete must agree to participate in the Student Assistance Program (SAP) assessment process (SHARE), an administratively approved program.

A. First Violation

*student-athlete will be suspended from the team for:

1. a. Sports with 12 or less matches: one (1) game
b. Other sports: (13 or more): two (2) games

B. Second Violation

*any student-athlete violating the District Drug and Alcohol Policy for the second time will be dismissed for:

1. Remainder of the season

C. Third Violation

*any student-athlete violating the District Drug and Alcohol Policy for the third time will not be permitted to participate in any athletic program for the remainder of their scholastic career.

** Violations to the Drug and Alcohol Policy are cumulative for the entirety of a student-athletes scholastic career.

*** The Athletic Director and/or EASD Administration reserve the right to evaluate any and all punishments warranted to the offense. In certain cases, some first-time offenses are serious enough to warrant any of the possible sanctions listed above. In all cases consideration will be given to individual circumstances.

STUDENT ATHLETE SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PARENT/GUARDIAN 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 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 (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 performed earlier than June 1st and shall be effective, regardless of when performed during a school year, until the next May 31st.

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, will then determine whether Section 6 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 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 _____ 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.

Sport	Signature of Parent or Guardian
Baseball (Spring)	
Basketball (Winter)	
Bowling (Winter)	
Cross Country (Fall)	
Field Hockey (Fall)	
Football (Fall)	
Golf (Fall)	
Gymnastics (Winter)	
Lacrosse (Spring)	
Rifle (Winter)	
Soccer (Fall)	
Soccer-Girls (Spring)	
Softball (Spring)	
Swimming & Diving	
Tennis-Girls (Fall)	
Tennis-Boys (Spring)	
Track-Indoor (Winter)	
Track & Field (Spring)	
Volleyball-Girls (Fall)	
Volleyball-Boys (Spring)	
Water Polo (Fall)	
Wrestling (Winter)	
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 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.

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.**

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	23. Has a doctor ever told you that you have asthma or allergies?	<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"/>	24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<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"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that apply):			30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur			31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			32. Have you been hit in the head and been confused or lost your memory?	<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"/>	33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<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"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<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"/>
14. Does anyone in your family have Marfan syndrome?	<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"/>
15. Have you ever spent the night in a hospital?	<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"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<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"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<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"/>	42. Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest			43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes			44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<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"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
			FEMALES ONLY		
			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. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

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: 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) _____ 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 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		
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) Date of CIPPE ____/____/____

SECTION 5: 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 6, 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 No</p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></p> <p>2. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? Yes No</p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></p> | <p>3. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? Yes No</p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></p> <p>4. Since completion of the CIPPE, are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills? Yes No</p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></p> <p>5. Do you have any concerns that you would like to discuss with a physician? Yes No</p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></p> |
|--|---|

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 6: 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 4 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 6 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.

NOTE: The physician completing this Form must first review Sections 3 and 4 of the herein named student's previously completed CIPPE Form. Section 5 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 5.

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 4 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 4 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 7: 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. 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, Scholastic Edition (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 Optimal Performance Calculator, Scholastic Edition, 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)

NOTE: Any athlete who disagrees with the Initial Assessment may appeal the assessment results one time by having a second assessment performed. The second assessment must utilize either Air Displacement Plethysmography (Bod Pod) or Hydrostatic Weighing testing to determine body fat percentage. Results obtained at the second assessment shall supersede the Initial Assessment and are automatically accepted; no further appeal by any party is permitted. All costs incurred in the second assessment are the responsibility of those appealing the Initial Assessment. The urine specific gravity testing will be conducted and the athlete will need to have a result of less than or equal to 1.025 in order for the second assessment to proceed.