Parent/Guardian –

We are happy your child has indicated a desire to participate in the school district's athletic program.

In order for your child to participate in athletics without problem of medical expenses being paid, you must sign and return the enclosed form. In case of injury, prompt medical care will be provided for your child on the basis of YOUR medical coverage under YOUR INSURANCE. For families without medical coverage, a student accident policy is made available through Robert A. Simonin Insurance Agency (724-745-9620), which covers all sports EXCEPT FOOTBALL. The Canon-McMillan School District will not assume medical responsibility for any injury sustained while engaging in a district athletic activity.

The school district purchases the best possible equipment for our athletes. The cost of outfitting our athletes is increasing each year. We would appreciate the parents' assistance in controlling the loss of the district's equipment. Equipment will be issued to all athletes at the beginning of the sport season and collected at the end of the season. It is the athlete's responsibility to return the same equipment that was issued at the beginning of the season. Any athlete who has lost, stolen or kept the equipment MUST PAY for it. It is your child's responsibility to take proper care of his/her own equipment.

The district is pleased to have your child participate in its athletic program. They should understand that being selected to represent their school in an interscholastic athletic activity is a privilege.

GOOD LUCK THIS SEASON!!

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 seven Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, 5 and 6 by the student and parent/guardian; and Section 7 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 8 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 9 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 _____

_____

Revised: April 27, 2021 BOD approved

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) occurs when the heart suddenly and unexpectedly stops beating. 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 350,000 cardiac arrests that occur outside of hospitals each year. More than 10,000 individuals under the age of 25 die of SCA each year. SCA is the number one killer of student athletes and the leading cause of death on school campuses.

Are there warning signs?

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

- Dizziness or lightheadedness when exercising;
- Fainting or passing out during or after exercising;
- Shortness of breath or difficulty breathing with exercise, that is not asthma related;
- Racing, skipped beats or fluttering heartbeat (palpitations)
- Fatigue (extreme or recent onset of tiredness)
- Weakness;
- Chest pains/pressure or tightness during or after exercise.

These symptoms can be unclear and confusing in athletes. Some may ignore the signs or think they are normal results off physical exhaustion. If the conditions that cause SCA are diagnosed and treated before a life-threatening event, sudden cardiac death can be prevented in many young athletes.

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

There are significant risks associated with continuing to practice or play after experiencing these symptoms. The symptoms might mean something is wrong and the athlete should be checked before returning to play. When the heart stops due to cardiac arrest, 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 experience a SCA die from it; survival rates are below 10%.

Act 73 – Peyton's Law - Electrocardiogram testing for student athletes

The Act is intended to help keep student-athletes safe while practicing or playing by providing education about SCA and by requiring notification to parents that you can request, at your expense, an electrocardiogram (EKG or ECG) as part of the physical examination to help uncover hidden heart issues that can lead to SCA.

Why do heart conditions that put youth at risk go undetected?

- Up to 90 percent of underlying heart issues are missed when using only the history and physical exam;
- Most heart conditions that can lead to SCA are not detectable by listening to the heart with a stethoscope during a routine physical; and
- Often, youth don't report or recognize symptoms of a potential heart condition.

What is an electrocardiogram (EKG or ECG)?

An ECG/EKG is a quick, painless and noninvasive test that measures and records a moment in time of the heart's electrical activity. Small electrode patches are attached to the skin of your chest, arms and legs by a technician. An ECG/EKG provides information about the structure, function, rate and rhythm of the heart.

Why add an ECG/EKG to the physical examination?

Adding an ECG/EKG to the history and physical exam can suggest further testing or help identify up to two-thirds of heart conditions that can lead to SCA. An ECG/EKG can be ordered by your physician for screening for cardiovascular disease or for a variety of symptoms such as chest pain, palpitations, dizziness, fainting, or family history of heart disease.

- ECG/EKG screenings should be considered every 1-2 years because young hearts grow and change.
- ECG/EKG screenings may increase sensitivity for detection of undiagnosed cardiac disease but may not prevent SCA.
- ECG/EKG screenings with abnormal findings should be evaluated by trained physicians.
- If the ECG/EKG screening has abnormal findings, additional testing may need to be done (with associated cost and risk) before a diagnosis can be made, and may prevent the student from participating in sports for a short period of time until the testing is completed and more specific recommendations can be made.
- The ECG/EKG can have false positive findings, suggesting an abnormality that does not really exist (false positive findings occur less when ECG/EKGs are read by a medical practitioner proficient in ECG/EKG interpretation of children, adolescents and young athletes).
- ECGs/EKGs result in fewer false positives than simply using the current history and physical exam.

The American College of Cardiology/American Heart Association guidelines do not recommend an ECG or EKG in asymptomatic patients but do support local programs in which ECG or EKG can be applied with high-quality resources.

Removal from play/return to play

Any student-athlete who has signs or symptoms of SCA must be removed from play (which includes all athletic activity). The symptoms can happen before, during, or after activity.

Before returning to play, the athlete must be evaluated and cleared. 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 this form and understand the symptoms and warning signs of SCA. I have also read the information about the electrocardiogram testing and how it may help to detect hidden heart issues.

_____ _____ Date____/____/_____

Signature of Student-Athlete — Print Student-Athlete's Name

_____ _____ Date____/____/_____

Signature of Parent/Guardian — Print Parent/Guardian's Name

Section 5: SUPPLEMENTAL ACKNOWLEDGEMENT, WAIVER AND RELEASE: COVID-19

The COVID-19 pandemic presents athletes with a myriad of challenges concerning this highly contagious illness. Some severe outcomes have been reported in children, and even a child with a mild or even asymptomatic case of COVID-19 can spread the infection to others who may be far more vulnerable.

While it is not possible to eliminate all risk of being infected with or furthering the spread of COVID-19, PIAA has urged all member schools to take necessary precautions and comply with guidelines from the federal, state, and local governments, the CDC and the PA Departments of Health and Education to reduce the risks to athletes, coaches, and their families. As knowledge regarding COVID-19 is constantly changing, PIAA reserves the right to adjust and implement precautionary methods as necessary to decrease the risk of exposure to athletes, coaches and other involved persons. Additionally, each school has been required to adopt internal protocols to reduce the risk of transmission.

The undersigned acknowledge that they are aware of the highly contagious nature of COVID-19 and the risks that they may be exposed to or contract COVID-19 or other communicable diseases by permitting the undersigned student to participate in interscholastic athletics. We understand and acknowledge that such exposure or infection may result in serious illness, personal injury, permanent disability or death. We acknowledge that this risk may result from or be compounded by the actions, omissions, or negligence of others. The undersigned further acknowledge that certain vulnerable individuals may have greater health risks associated with exposure to COVID-19, including individuals with serious underlying health conditions such as, but not limited to: high blood pressure, chronic lung disease, diabetes, asthma, and those whose immune systems that are compromised by chemotherapy for cancer, and other conditions requiring such therapy. While particular recommendations and personal discipline may reduce the risks associated with participating in athletics during the COVID-19 pandemic, these risks do exist. Additionally, persons with COVID-19 may transmit the disease to others who may be at higher risk of severe complications.

By signing this form, the undersigned acknowledge, after having undertaken to review and understand both symptoms and possible consequences of infection, that we understand that participation in interscholastic athletics during the COVID-19 pandemic is strictly voluntary and that we agree that the undersigned student may participate in such interscholastic athletics. The undersigned also understand that student participants will, in the course of competition, interact with and likely have contact with athletes from their own, as well as other, schools, including schools from other areas of the Commonwealth. Moreover, they understand and acknowledge that our school, PIAA and its member schools cannot guarantee that transmission will not occur for those participating in interscholastic athletics.

NOTWITHSTANDING THE RISKS ASSOCIATED WITH COVID-19, WE ACKNOWLEDGE THAT WE ARE VOLUNTARILY ALLOWING STUDENT TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS WITH KNOWLEDGE OF THE DANGER INVOLVED. WE HEREBY AGREE TO ACCEPT AND ASSUME ALL RISKS OF PERSONAL INJURY, ILLNESS, DISABILITY AND/OR DEATH RELATED TO COVID-19, ARISING FROM SUCH PARTICIPATION, WHETHER CAUSED BY THE NEGLIGENCE OF PIAA OR OTHERWISE.

We hereby expressly waive and release any and all claims, now known or hereafter known, against the student's school, PIAA, and its officers, directors, employees, agents, members, successors, and assigns (collectively, "**Releasees**"), on account of injury, illness, disability, death, or property damage arising out of or attributable to Student's participation in interscholastic athletics and being exposed to or contracting COVID-19, whether arising out of the negligence of PIAA or any Releasees or otherwise. We covenant not to make or bring any such claim against PIAA or any other Releasee, and forever release and discharge PIAA and all other Releasees from liability under such claims.

Additionally, we shall defend, indemnify, and hold harmless the student's school, PIAA and all other Releasees against any and all losses, damages, liabilities, deficiencies, claims, actions, judgments, settlements, interest, awards, penalties, fines, costs, or expenses of whatever kind, including attorney fees, fees, and the costs of enforcing any right to indemnification and the cost of pursuing any insurance providers, incurred by/awarded against the student's school, PIAA or any other Releasees in a final judgment arising out or resulting from any claim by, or on behalf of, any of us related to COVID-19.

We willingly agree to comply with the stated guidelines put forth by the student's school and PIAA to limit the exposure and spread of COVID-19 and other communicable diseases. We certify that the student is, to the best of our knowledge, in good physical condition and allow participation in this sport at our own risk. By signing this Supplement, we acknowledge that we have received and reviewed the student's school athletic plan.

Date: _____

_____

Signature of Student | Print Student's Name

_____

Signature of Parent/Guardian | Print Parent/Guardian's Name

Revised – October 7, 2020

Student's Name _____ Age_____ Grade_____

SECTION 6: HEALTH HISTORY

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

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sport(s) for any reason?	❑	❑
2.	Do you have an ongoing medical condition (like asthma or diabetes)?	❑	❑
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	❑	❑
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	❑	❑
5.	Have you ever passed out or nearly passed out DURING exercise?	❑	❑
6.	Have you ever passed out or nearly passed out AFTER exercise?	❑	❑
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	❑	❑
8.	Does your heart race or skip beats during exercise?	❑	❑
9.	Has a doctor ever told you that you have (check all that apply): ❑ High blood pressure ❑ Heart murmur ❑ High cholesterol ❑ Heart infection	❑	❑
10.	Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	❑	❑
11.	Has anyone in your family died for no apparent reason?	❑	❑
12.	Does anyone in your family have a heart problem?	❑	❑
13.	Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	❑	❑
14.	Does anyone in your family have Marfan Syndrome?	❑	❑
15.	Have you ever spent the night in a hospital?	❑	❑
16.	Have you ever had surgery?		
17.	Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:	❑	❑
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	❑	❑
19.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	❑	❑

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes

20.	Have you ever had a stress fracture?	❑	❑
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	❑	❑
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?	❑	❑
24.	Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	❑	❑
25.	Is there anyone in your family who has asthma?	❑	❑
26.	Have you ever used an inhaler or taken asthma medicine?	❑	❑
27.	Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	❑	❑
28.	Have you had infectious mononucleosis (mono) within the last month?	❑	❑
29.	Do you have any rashes, pressure sores, or other skin problems?	❑	❑
30.	Have you ever had a herpes skin infection?	❑	❑
	CONCUSSION OR TRAUMATIC BRAIN INJURY		
31.	Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	❑	❑
32.	Have you been hit in the head and been confused or lost your memory?	❑	❑
33.	Do you experience dizziness and/or headaches with exercise?	❑	❑
34.	Have you ever had a seizure?	❑	❑
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	❑	❑
36.	Have you ever been unable to move your arms or legs after being hit or falling?	❑	❑
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	❑	❑
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	❑	❑
39.	Have you had any problems with your eyes or vision?	❑	❑
40.	Do you wear glasses or contact lenses?	❑	❑
41.	Do you wear protective eyewear, such as goggles or a face shield?	❑	❑
42.	Are you unhappy with your weight?	❑	❑
43.	Are you trying to gain or lose weight?	❑	❑
44.	Has anyone recommended you change your weight or eating habits?	❑	❑
45.	Do you limit or carefully control what you eat?	❑	❑
46.	Do you have any concerns that you would like to discuss with a doctor?	❑	❑
	FEMALES ONLY	❑	❑
47.	Have you ever had a menstrual period?	❑	❑
48.	How old were you when you had your first menstrual period?	_____	
49.	How many periods have you had in the last 12 months?	_____	
50.	Are you pregnant?	❑	❑

#'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 7: 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		❑ Heart murmur ❑ Femoral pulses to exclude aortic coarctation ❑ 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 8: 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 9, 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 # ( )_____

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 9, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.
Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

	Yes	No
1. Since completion of the CIPPE, have you sustained a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine?	❑	❑
An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below		
2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	❑	❑
3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?	❑	❑
4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	❑	❑
5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills?	❑	❑
6. Do you have any concerns that you would like to discuss with a physician?	❑	❑

#'s	Explain yes answers; include injury, type of treatment & the name of the medical professional seen by student

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 9: 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 9 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 6 and 7 of the herein named student's previously completed CIPPE Form. Section 8 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 8.

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 10: 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____ wresting 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.

Allegheny
Health Network

Sports Medicine

Patient Name: _____ Date: _____

Date of Birth: (xx/xx/xxxx) : _____ Last 4 (Four) digits of SSN: _____

Address: _____

Phone Number: _____ Fax Number: _____

Authorization for Release of Protected Health Information

I hereby authorize the West Penn Allegheny Health System, Inc. – Allegheny General Hospital certified athletic trainer(s) and team physician(s) to release my Protected Health Information (PHI):

Please choose who will receive the information and the method of delivery. Be certain that information is accurate and complete. Incomplete authorizations are invalid.

☐ School Administration, Athletic Directors, Secretaries, Nurses and Coaches (if student), and parent (if student is 18 or older):

The PHI I would like to have released is as follows:

☐ Athletic/Sports Related Injuries Only

☐ Release my entire chart (I understand that information may include acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus; mental health care; treatment for alcohol and/or drug abuse; and sexually transmitted disease unless otherwise indicated).

Do not release: ☐ AIDS/HIV ☐ Mental Health History ☐ Drug & Alcohol

☐ Other (specifically identify exact information to be disclosed, including specific dates of service):

_____

- I understand that this Authorization shall expire one (1) year from the date of signature unless otherwise specified below.
- I understand that I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this Authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization.
- I understand that I am not required to sign this Authorization as condition of my obtaining treatment.
- I understand that, to extent that any recipient of this information, as identified above, is not a "covered entity" under Federal Law, the information may no longer be protected by federal and state law. I understand that, in these circumstances, the individual receiving this information may be permitted to re-disclose the information. I understand that my healthcare provider is not responsible should the individual receiving this information re-disclose the information.
- I am entitled to a copy of this completed Authorization upon my request.

- I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent, Legal Guardian or Authorized Representative Date

_____ _____
Witness/Staff Member Signature Date

If signed by an Authorized Representative, complete the following:
Printed Name of Personal Representative: _____
Description of Authority to act for individual: _____

Oral Authorization
Only to be used if patient is physically unable to sign. This is NOT applicable to HIV related information or Drug & Alcohol Treatment.
I witness that the nature of this release has been explained to the patient, that the patient understood the nature of the release and freely gave oral authorization (two witnesses are required).
Witness: _____ Witness: _____
Date: _____ Date: _____

Authorization for Consent of Treatment, by Licensed Athletic Trainer(s)/Team Physicians, Within the Scope of Practice

I, _____ (printed name of parent, legally authorized representative, or athlete if over 18) hereby authorize West Penn Allegheny Health System, Inc. – Allegheny General Hospital (AGH)Certified Athletic Trainer(s)/Team Physicians to provide only those services they are qualified through education or experience and which is allowed by their practice acts and other pertinent regulation.

This authorization is valid for 1 calendar year from the date below.

I understand that this authorization is subject to revocation at any time, except to the extent that West Penn Allegheny Health System, Inc. – Allegheny General Hospital has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing to AGH (1307 Federal Street, Suite 500, Pittsburgh, PA 15212).

_____
Parent, Guardian, or Athlete (if over 18) Signature Date Witness