

SPORTS MEDICINE INFORMATION FORM

CONESTOGA VALLEY SCHOOL DISTRICT

PLEASE PRINT CLEARLY IN INK

Student Name _____ Date of Birth _____ Grade _____ Gender _____

Fall Sport _____ Winter Sport _____ Spring Sport _____

Street Address _____ City _____ Zip Code _____

Mailing Address (if different from street address) _____ Home Phone _____

Mother/Guardian _____

Father/Guardian _____

Cell Phone _____

Cell Phone _____

Work Phone _____

Work Phone _____

E-mail _____

E-mail _____

Alternate Emergency Contact _____

Relationship _____

Home Phone _____

Cell Phone _____

Date of Student's Most Recent Tetanus Immunization _____

Hospital Preference _____

Medical Conditions Which May Affect Athletic Activity _____

PARENT/GUARDIAN PERMISSION:

I grant permission for my child to have injuries and illnesses treated by the athletic trainer and team physician and for medical personnel, at their discretion, to release school health record medical information to those individuals deemed necessary by the medical personnel. I understand that all injuries and illnesses must be reported to the athletic trainer.

I understand that if I choose to have my child treated by another healthcare provider, I am responsible to obtain a letter of clearance from that provider to the athletic trainer. I understand that the athletic trainer and the team physician have final authority to clear or to disqualify my child for activity following any injury or illness.

I grant permission for the athletic trainer or team physician to administer any of the following medications not crossed out:
acetaminophen, ibuprofen, Benadryl, antacid tablets, throat lozenges

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 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 | • Feeling sluggish, hazy, foggy, or groggy |
| • Nausea or vomiting | • Difficulty paying attention |
| • Balance problems or dizziness | • Memory problems |
| • Double or blurry vision | • Confusion |
| • Bothered by light or noise | |

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		Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	☐	☐	23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
2. Do you have an ongoing medical condition (like asthma or diabetes)?	☐	☐	24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐	25. Is there anyone in your family who has asthma?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐	26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐	28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐	30. Have you ever had a herpes skin infection?	☐	☐
9. Has a doctor ever told you that you have (check all that apply):			CONCUSSION OR TRAUMATIC BRAIN INJURY 31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? ☐ Yes ☐ No 32. Have you been hit in the head and been confused or lost your memory? ☐ Yes ☐ No 33. Do you experience dizziness and/or headaches with exercise? ☐ Yes ☐ No		
☐ High blood pressure ☐ Heart murmur			34. Have you ever had a seizure?	☐	☐
☐ High cholesterol ☐ Heart infection			35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	☐	☐	36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐	37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	☐	☐	39. Have you had any problems with your eyes or vision?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐	40. Do you wear glasses or contact lenses?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐	41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
16. Have you ever had surgery?	☐	☐	42. Are you unhappy with your weight?	☐	☐
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:	☐	☐	43. Are you trying to gain or lose weight?	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐	44. Has anyone recommended you change your weight or eating habits?	☐	☐
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:	☐	☐	45. Do you limit or carefully control what you eat?	☐	☐
Head Neck Shoulder Upper arm Elbow Forearm Hand/Fingers Ankle Chest			46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
Upper back Lower back Hip Thigh Knee Calf/shin Foot/Toes			FEMALES ONLY		
20. Have you ever had a stress fracture?	☐	☐	47. Have you ever had a menstrual period?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐	48. How old were you when you had your first menstrual period?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐	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 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		☐ 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 ____/____/____