



BLOOMSBURG ATHLETICS



To: All 2025-2026 Students/Parents/Guardians in Grades 7-12
From: Mike Kogut, Athletic Director
570-784-6100 x9 mkogut@bloomsd.org
Re: BASD Required Medical Paperwork for Athletic Participation
Date: 6/9/2025

- The following paperwork required medical paperwork to participate in BASD Athletics:
 - ✓ HIPPA Authorization Form
 - ✓ PIAA CIPPE Packet (Sections 1-6) with required information, signatures & completed physical
 - ✓ 2025-26 Emergency Contact Form
- The BASD offers athletic physicals **FREE OF CHARGE**. Physical examinations will take place on 7/31/25 & 8/1/25 from 9:00 am-1:00 pm in the Middle School Gym. You must do the following to receive a physical:
 - ✓ Complete and return all required paperwork (excluding CIPPE Section 6) to Mr. Kogut in the Central Office (OPEN 8AM-2PM MONDAY THROUGH FRIDAY) no later than FRIDAY, JULY 25, 2025
 - ✓ **DO NOT RETURN THIS PACKET TO YOUR COACH!**
 - ✓ Students who have their packet completed in full will be given a choice to choose EITHER DATE and schedule an available time slot that best fits their schedule (EX: 8/1 @ 9:10 AM)
 - ✓ Students will NOT be eligible if they do not have their paperwork in by FRIDAY, JULY 25, 2025
- Students can choose to get a physical examination on their own. The following applies if you choose this option:
 - ✓ The cost will be incurred by the student/family
 - ✓ The CIPPE form MUST be used when you are examined & must be the most current (July 17, 2024)
 - ✓ Physicals completed before MAY 1, 2025 are INVALID and CANNOT be accepted. This is a PIAA rule!
- You CANNOT participate in athletics if you fail to have all paperwork completed as well as a physical exam
- Winter & Spring athletes can schedule physicals, but will need Section 7 completed when their season begins

FALL 2025 IMPORTANT INFORMATION

SPORT	COACH'S NAME	EMAIL	PIAA OFFICIAL PRACTICE DATE
JH & Varsity XC	Nick Troychock	coachnicktroychock@gmail.com	8/11/2025
Girls Tennis	Phil Burrell	pburrell@bloomsd.k12.pa.us	8/4/2025
Girls Soccer	Aaron Flook	aflook@bloomsd.k12.pa.us	8/11/2025
Boys Soccer	Dan Kelly	dk05@hotmail.com	8/11/2025
Field Hockey	Chuck Baker	cbaker_03@yahoo.com	8/11/2025
Varsity Golf	Jonathan Barnett	jbarnett@bloomsd.k12.pa.us	8/11/2025
JH & Varsity Cheer	Rachel Flick	spoon137@gmail.com	8/11/2025
JH Softball	Chris Long	calong2@geisinger.edu	8/11/2025
JH & Varsity FB	Mike Kogut	mkogut@bloomsd.k12.pa.us	8/4/2025 (VAR) 8/11/2025 (JH)

MANDATORY HIPAA FORM FOR ATHLETES

All student athletes are required to complete and return the following RELEASE form. This form will be required to ensure that we are following the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA law was put in place to ensure confidentiality of individuals requiring medical care. Every athlete has their individual rights protected for medical records. Even though our Certified Athletic Trainers have “shared” medical information on the athletes for years between Physicians and coaches, we must now by federal law have a signed authorization form permitting Geisinger to disclose protected health information about the student/athlete to the coaching staff. This would include the injury specifics, severity of the injury, and the status to return to play. For your son/daughter to be able to participate in athletics, a copy of this form will need to be on file at the school. This form will only need to be completed one time per year prior to the start of the sport season. These forms will be available in the main office at your school. We appreciate your help in ensuring that this form is completed and turned in prior to your son/daughter’s sports season.

Sincerely,

Mike Elder, MS, LAT, ATC, CSCS
Program Manager of Sports Medicine
Musculoskeletal Institute
Geisinger
16 Woodbine Lane
Danville, PA 17822-5212
Office 570-271-6700 Option 3
mdelder@geisinger.edu



**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 May 1st and shall be effective, regardless of when performed during a school year, until the latter of the next April 30th 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)

Student's Date of Birth: ____/____/____ Student's Age on Last Birthday: _____ Grade _____ for 20 25 - 20 26
School Year

Current Physical Address _____

Current Home Phone # () _____ Parent/Guardian Current Cellular Phone # () _____

Parent/Guardian E-mail Address: _____

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:** 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 7 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.

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? ☐ ☐ 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? ☐ ☐ MENSTRUAL QUESTIONS- IF APPLICABLE 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. When was your last menstrual period? _____																		
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: ☐ ☐																					
<table border="0" style="width: 100%; font-size: small;"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Upper arm</td> <td>Elbow</td> <td>Forearm</td> <td>Hand/ Fingers</td> <td>Chest</td> </tr> <tr> <td>Upper back</td> <td>Lower back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/shin</td> <td>Ankle</td> <td>Foot/ Toes</td> </tr> </table>	Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest	Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes					
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?	☐	☐																			

#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 _____ for 20____ - 20____
School Year

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 7: RE-CERTIFICATION BY PARENT/GUARDIAN

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

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

SUPPLEMENTAL HEALTH HISTORY

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

Student's Date of Birth: ____/____/____ Student's Age on Last Birthday: ____ Grade ____ for 20____ - 20____ 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 _____

Parent/Guardian E-mail Address: _____

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 8, 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? | ☐ | ☐ |
|--|--------------------------|--------------------------|

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 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 8: Re-CERTIFICATION BY LICENSED PHYSICIAN OF MEDICINE OR OSTEOPATHIC MEDICINE

This Form must be completed for any student who, subsequent to completion of Sections 1 through 5 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 8 may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to the Principal, or the Principal's designee, of the student's school, who, pursuant to ARTICLE X, LOCAL MANAGEMENT AND CONTROL, Section 2, Powers and Duties of Principal, subsection C, of the PIAA Constitution, shall "exclude any contestant who has suffered serious illness or injury until that contestant is pronounced physically fit by the school's licensed physician of medicine or osteopathic medicine, or if none is employed, by another licensed physician of medicine or osteopathic medicine."

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

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

Student's Name: _____ Age _____ Grade _____ for 20____ - 20____
School Year

Enrolled in _____ School

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

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

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

Address _____ Phone () _____

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

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

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

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

Address _____ Phone () _____

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

Section 9: CIPPE MINIMUM WRESTLING WEIGHT

INSTRUCTIONS

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

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

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

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

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

INITIAL ASSESSMENT

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

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

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

Assessor's Signature _____ Date ____/____/____

CERTIFICATION

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

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

Address _____ Phone () _____

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

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

NOTES:

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

AUTHORIZATION TO RELEASE ATHLETIC MEDICAL INFORMATION

Patient Name: _____
Address: _____
Address: _____
Birthdate: _____
Medical Record No.: _____

• GEISINGER EMPLOYEE USE ONLY •

☒ Geisinger Medical Center ☒ Geisinger Wyoming Valley Medical Center ☒ Geisinger Clinic (GMG)
100 N. Academy Avenue 1000 E. Mountain Boulevard
Danville, PA 17822 Wilkes-Barre, PA 18711
(AS APPLICABLE) (Specify site and address)

I authorize an appropriate workforce member of the above entity(ies) to release information from my medical record to: Officials of the school that I (Student Athlete) attend-BLOOMSBURG AREA SD. This would include, the coaching staff, athletic directors, insurance carriers and health-care professionals who are involved with my participation in interscholastic athletics.

BLOOMSBURG AREA SD 728 EAST FIFTH ST. BLOOMSBURG, PA 17815 570-784-5000

(Address and Phone number of receiving party)

for the purpose of: X continuation of medical treatment X payment of bill X Worker's Compensation
X education X legal purposes X insurance purposes X at the request of the patient or the patient's legal representative for personal access or other (specify): _____

The information to be released will cover the time period from 6/1/2025 to 6/1/2026

SPECIFIC INFORMATION TO RELEASE:

-All information concerning my health that impacts my ability to participate in interscholastic athletics.

This may include information about injuries (such as sprains), surgeries, or medical conditions (such as concussions, asthma etc.). This is to inform the above referenced people of my health -related limitations and abilities to continue to participate in interscholastic athletics.

-To provide the above referenced people with information on how to help me safely participate in interscholastic athletics

I understand that to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact the above entity(ies) immediately if I wish to revoke this authorization. As described in the Notice of Privacy Practices for the above entity(ies), I may request such Notice of Privacy Practices for my ease of reference. I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations). The above entity(ies) may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party.

SPECIAL AUTHORIZATION (if applicable)

If you are authorizing the above entity(ies) to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.

Parent/Guardian Patient/athlete My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence maybe released to the recipient noted above.

Parent/Guardian Patient/athlete My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation and/or neuro-psychological information may be released to the recipient noted above.

Parent/guardian Patient/athlete My testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted above.

AUTHORIZATION SIGNATURES

Date: _____ Patient/Athlete Signature: _____

Date: _____ Witness Signature: _____

Date: _____ Parent/Guardian Signature: _____

Date: _____ Witness Signature: _____

*****COPY OF COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT*****

Copy: Medical Record

Copy: Patient



Bloomington Area School District
Athletic Department
1100 Railroad Street Bloomington, PA 17815
Phone: 570-784-5000 Fax: 570-387-8832
Web Site: <https://www.bloomingtonsd.org>

2025-26 ATHLETE EMERGENCY CONTACT INFORMATION

SPORT: _____

NAME:	
STREET ADDRESS:	
CITY/STATE/ZIP CODE:	
PRIMARY CONTACT NAME:	
PRIMARY CONTACT TELEPHONE #:	
RELATIONSHIP TO ATHLETE:	
SECONDARY CONTACT NAME:	
SECONDARY CONTACT TELEPHONE #:	
RELATIONSHIP TO ATHLETE:	
PCP NAME:	
PCP TELEPHONE #:	
BLOOD TYPE:	
PRE-EXISTING MEDICAL CONDITIONS:	
ALLERGIES OR ALLERGIC REACTIONS:	
CURRENT MEDICATIONS:	
LAST TETANUS IMMUNIZATION:	
OTHER PERTINENT INFORMATION:	
NAME OF INSURANCE CARRIER:	
POLICY/GROUP NUMBER:	

The information on this form is confidential and for emergency use only. In the event of an emergency while participating in an athletic event, the information will be used by BASD staff and medical personnel. Please provide accurate information. In case of an emergency, I give permission for the student-athlete to be treated and for my information to be released for emergency purposes. I also agree that any of my emergency contacts listed on this card may be notified in an emergency, as needed.

Parent/Guardian Signature: _____

****This will be placed in a binder and be readily available at all times****

