ATHLETIC PHYSICALS

Athletic physicals have been scheduled for the 2026/2027 school year. The law requires that every student participating in Interscholastic Athletic Activities must have a physical prior to participation. One physical will cover the entire school year. The school district provides a physical at no cost, provided the student appears for the physical on the scheduled date. This will be the only date the school will provide physicals. There will be no make-up dates.

The school district will not be responsible for payment of any physical that is not taken on this date or if a student chooses to have their own private physician administer their physical.

All physical forms must be handed into the High School Office.

Please have the entire PIAA Comprehensive Initial Pre-Participation Physical Evaluation Form (C.I.P.P.E) completed **prior to reporting for your physical.**

All athletic physicals, whether provided by the school or private, must have the completed C.I.P.P.E. form completed by parent and physician.

Also included in your packet are the:

- *Drug Testing permission form*
- *Pay to Play Form (This form must accompany payment. Please pay in the High School Office).*

Physical packets can be accessed on our website, or pick one up in the high school office.

Date: Thursday's, June 11 and 25, 2026 9 – 3pm

Location: Avella High School

Avella Area School District

Pre-Participation

Player Packet 2026/2027

A Pre-Participation physical is required by the P.I.A.A. for all candidates for athletic teams. Only one physical per year will be necessary unless there is a serious illness or injury during the year. The physical will be in effect for the school year, beginning May 1 2026 through April 30, 2027. Students participating in subsequent sports in the same school year must obtain and complete Section 7 of the C.I.P.P.E. form and must turn it in to the High School Office, who will then determine whether Section 8 needs to be completed.

Name of Athlete _____

Grade _____

Parent/Guardian _____

Address _____

_____

Home Phone _____

Emergency/Alternate Phone _____

Fall _____

Winter _____

Spring _____

No student will be permitted to begin regular season practices without a completed Physical Packet.

AVELLA AREA S.D. – ATHLETIC DEPARTMENT

Dear Parent/Guardian,

Your son/daughter has indicated a desire to participate in the athletic program offered by the Avella Area School District. We encourage his/her participation in our formal athletic programs, but feel that it is necessary to explain to you the school policy regarding participation.

All student athletes must have health insurance. You undoubtedly carry your child under Blue Cross, Blue Shield or other insurance coverage which is provided by either your employer or by your directly.

The Avella School District will provide insurance for your child during the regular school day and for all school sponsored activities, including any sport that the student participates in during the 2025/2026 school year. This insurance will be provided at no cost to the parent and or guardian.

In order for your child to participate in the athletic program of the district, you **must** sign and return the enclosed forms. In the event of injury, prompt medical care will be provided for you child on the basis of your medical coverage under **your** insurance.

Insurance claims are processed using the following procedures.

- In the case of an athletic injury, an accident form is completed, by the athletic trainer, coach, or sponsor. Copies of this completed form are kept in the high school office.
- Costs associated with this injury are to initially be submitted to the parent/guardian health coverage.
- The Avella School District Insurance will cover any remaining cost that your original insurance did not cover. Once it is determined that you have unpaid claims, you may obtain an insurance form from the high school office. This form will give you all of the information necessary to submit your claims.

The school district purchases the best possible equipment for our athletes. The cost of outfitting our athletes is increasing tremendously each year. Therefore, 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 season and collected at the end of the season. Any student who has **lost, had stolen, or kept** the equipment, **must pay for the equipment**. With your assistance, I am sure that we can eliminate any future problems.

Students should understand and keep in mind that being selected to represent their school in an interscholastic athletic activity is a privilege. All should realize that participation in athletics is part of a total education experience. The district is pleased to have your child participate in its' athletic program.

Thank you very much for your cooperation,

Sincerely,

Jason Fogg

Athletic Director

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____- 20____ 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: CERTIFICATIONS

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____/____/_____

Student'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____/____/_____

Student'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____/____/_____

Student'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____/____/_____

Student'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____/____/_____

Student'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

Student's Name _____ Age_____ Grade_____ for 20____ - 20____
School Year

SECTION 5: HEALTH HISTORY

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

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sport(s) for any reason?	❑	❑
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?	❑	❑
	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?		

#'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?	❑	❑
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____ wresting season.

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

Address_____ Phone ( )_____

AME's Signature _____MD, DO, PAC, CRNP, or SNP (circle one) Date of Certification ___/___/___

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.

Avella Area School District

Drug Testing for Student Athletics
Permission to Test Consent Form

I HEREBY GIVE PERMISSION FOR THE AVELLA AREA SCHOOL DISTRICT AND (MEDICAL CLINIC) TO PERFORM A URINE DRUG SCREEN ON MY SON/DAUGHTER. I REALIZE THE PURPOSE AND RAMIFICATIONS OF THE TESTING AND WILL FOLLOW THE GUIDELINES SET FORTH FOR POSITIVE TESTS BY THE AVELLA AREA SCHOOL DISTRICT BOARD OF DIRECTORS.

I UNDERSTAND THAT MY SON/DAUGHTER WILL NOT BE PUNISHED BY SUSPENSION OR EXPULSION FOR A POSITIVE TEST RESULT, HOWEVER, THEY WILL BE DISQUALIFIED FROM PARTICIPATION IN THE ACTIVITY AS OUTLINED IN THE BOARD POLICY ON DRUG TESTING FOR STUDENT ATHLETES. I ALSO UNDERSTAND THAT MY SON/DAUGHTER WILL BE REQUIRED TO COMPLY WITH SPECIFIC GUIDELINES FOR FURTHER ATHLETIC CONSIDERATION AS SET FORTH IN THIS POLICY.

AVELLA AREA SCHOOL DISTRICT IS COMMITTED TO PROVIDING A SAFE, DRUG-FREE ATHLETIC PROGRAM. WE APPRECIATE YOUR SUPPORT, ENCOURAGEMENT AND COOPERATION. YOU MAY REQUEST TO BE PRESENT WHEN YOUR SON/DAUGHTER IS BEING TESTED. THE COST OF THE TEST WILL BE COVERED BY THE AVELLA AREA SCHOOL DISTRICT. PARENTS/GUARDIANS MUST PAY FOR THE DRUG AND ALCOHOL EVALUATION. TESTS WILL BE CONFIDENTIAL. THE SELECTION PROCESS WILL BE DONE BY A RANDOM SAMPLING PROCESS.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

AS A STUDENT ATHLETE, I AGREE TO PARTICIPATE IN THE URINE DRUG TESTING PROGRAM. I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED IN THIS PERMISSION TO TEST FORM. I ALSO AUTHORIZE THE RELEASE OF INFORMATION CONCERNING THE RESULTS OF SUCH A TEST TO THE AVELLA AREA SCHOOL DISTRICT AND TO MY PARENTS/GUARDIANS. THIS FULLY EXECUTED FORM REPRESENTS MY CONSENT AND MY PARENTS CONSENT PURSUANT TO THE FAMILY EDUCATION RIGHT TO PRIVACY ACT FOR THE RELEASE OF ABOVE INFORMATION TO THE PARTIES NAMED ABOVE.

_____ _____

STUDENT SIGNATURE DATE

Avella Area School District
Insurance Form

Dear Parents:

All student athletes must have health insurance.

The Avella School District will provide insurance for your child during the regular school day and for all school sponsored activities. This insurance will be provided at no cost to the parent.

School Time Accident Coverage - Paid for by the school

All students will have student accident coverage during the regular school day and for all school-sponsored activities, including any sport that the student participates in during the 2024/2025 school term.

Full Time 24-Hour Accident Coverage-Estimated Cost - $124.00

This plan will give the student insurance coverage 24 hours a day for one year. This covers weekends, vacations and the entire summer.

Information for Student Accident Insurance can be obtained in the High School Office.

Please tear off and return immediately

I permit _____ to participate in Sports.

Our family has the following health plan:

Name of Company: _____

Policy Number: _____

All medical costs that are not covered by the School Time Accident Insurance are the sole responsibility of the parent.

_____ _____

Signature of Parent or Guardian Date

AVELLA AREA SCHOOL DISTRICT
STUDENT SPORTS FEE CHECKLIST

SPORT: _____

Student Name: _____

Parents/Guardians: The established student activity fee is $100.00 per each school year. Activities that will be assessed fees include all school sports, including cheerleading.

Please complete this form for the activity of participation with all information requested; attach cash or check for $100.00 payable to Avella Area School District and submit to the JSHS Office. *Please write your child's name and activity in the memo portion of the check.*

I have paid by:

□ Cash □ Check # _____

□ Physical Completed □ Student Athlete Handbook, rules and conduct code read and understood

Note: I understand that the fee I am paying does not guarantee playing time or control over any conditions of the term or program, and is not refundable once a position on a team is secured or participation in an activity has started. In addition, I understand that the fee will not be refunded or prorated for a student who becomes injured or ineligible during the season, when a student is removed from a team for academic or disciplinary reasons, when cancelled contests cannot be rescheduled, or when a full allotment of games cannot be scheduled. In addition, I understand that the number of scheduled contests may vary from level to level and from school to school. I also understand that paying the fee does not alter the student athlete policies of the Avella Area School District or the regulations of the Pennsylvania Interscholastic Athletic Association, and individual team or activity rules.

_____ _____ _____

Signature of Student Signature of Parent/Guardian Parent/Guardian Print Name Here

_____

Address

_____

Phone E-Mail

Date: _____/_____/_____

IF FEES ARE NOT PAID WITHIN ONE (1) WEEK PRIOR TO THE FIRST ACTIVITY OR SPORT, STUDENTS WILL BE REMOVED UNTIL PAYMENT IS RENDERED.

Book	Policy Manual
Section	200 Pupils
Title	Participation in Athletics - Pay-to-Play
Code	253
Status	Active
Adopted	July 17, 2019
Last Revised	February 19, 2020

Purpose

In light of the serious financial constraints imposed upon the school district, the Board of School Directors has reviewed all avenues available to reduce expenses and increase revenues. As part of this process, the Board has determined that it is necessary at this time to establish a Pay-to-Play program with respect to the district's athletic program.

Guidelines

Students who wish to participate in the school district's interscholastic athletic program, and/or serve as Avella Area School District cheerleaders, will be required to pay $100.00 each year for the first sport in which they wish to participate and/or to participate as a cheerleader. No student will be required to pay more than $100.00 each year, regardless of the amount of sports in which s/he participates.

The Pay-to-Play fee for each sport and/or for the opportunity to participate as a cheerleader must be paid in full prior to the time that the student participates in tryouts for the activity, if tryouts are required, with the understanding that the fee will be refunded for those students who are not selected for the team/squad. The Pay-to-Play fee will not, however, be refunded once a position on a team/squad is secured or participation in an activity has started.

Payment of the Pay-to-Play fee does not guarantee any student playing/participation time or control over the conditions of the team or program.

The Pay-to-Play fee will not be refunded or prorated for a student who becomes injured or ineligible during the season, or for a student who is removed from the team/squad for academic or disciplinary reasons. The Pay-to-Play fee will also not be refunded because cancelled events or competitions cannot be rescheduled, or because a full allotment of games cannot be scheduled.

Students who wish to participate in the school district's interscholastic athletic program, and/or serve as cheerleaders for the school district, and the parents/guardians of all such students, will be required to execute an acknowledgment relating to these Pay-to-Play fee rules, at or before the time the Pay-to-Play fee is paid.

Students who wish to participate in the school district's interscholastic athletic program, and/or serve as cheerleaders for the school district, will continue to be required to complete physical examinations before tryouts, if any, or before participating in the activity, with the understanding that the students and/or their parents/guardians shall be fully responsible for obtaining, and paying for, such physicals.