

APPENDIX B

Please Sign and return each form to the Athletics Office or to the Athletic Trainer's office.

****The student athlete will not be allowed to participate in athletics until every form is turned in. The forms needed are listed below. ****

1. Marple Newtown Athletic Code of Conduct
2. Marple Newtown Emergency Medical / Consent Form
3. Understanding Non-medical/Misuse of Prescription Medications
4. PIAA CIPPE Sect. 1-6 (Must be signed by a Doctor after May 1, 2026 to be valid for 2026/2027 school year.
5. Marple Newtown Activity Fee Form

Physical Examinations

No student shall be eligible to represent his/her school in any interscholastic athletic contests unless he/she has been examined by a licensed physician of medicine before his/her first sports season of the academic year. Before each subsequent sports season of the same academic year, he/she will need to be re-certified by either a parent or physician in order to confirm that his/her condition is satisfactory before he/she begins to train or practice for the intended sport. All physical exam information will be kept on file in the athletic office.

Sections I-V (1-5) of the physical form must be filled out by a parent prior to a physical being given by a physician. Section VI (6) of the physical form is filled out by the physician.

***** THE PHYSICAL MUST BE Authorized AFTER May 1, 2026 TO BE VALID FOR THE 2026--2027 YEAR. *****

Season 2 and/or season 3 participation requires recertification by:

Re-certification by parent: This option is afforded to student athletes who finish their previous season deemed healthy by our athletic trainer. A parent can fill out Section VII (7) of the physical form to certify that there has been no change in the medical condition of their child since the date of their last physical.

Re-certification by a physician: This is required for any student athlete who finishes the previous season as an injured member of the team or any student who suffers an injury or change to their medical condition between seasons. Section VIII (8) must be filled out by a physician in order to certify that the student is deemed fit to participate in the new season.



MARPLE NEWTOWN SCHOOL DISTRICT

120 Media Line Road
Newtown Square, Pennsylvania 19073-4696
(610) 359-4218 • FAX: (610) 356-2194

Marple Newtown Athletic Code of Conduct

As a member of the Athletic Program in the Marple Newtown School District, I realize that participation in extracurricular activities is a privilege that must be upheld. I have read the student athlete/parent handbook and understand that I am required to meet the academic requirements put forth by the district, and also those requirements outlined by the coaches of the programs in which I am involved.

Any student posting things via a social media outlet must adhere to our Athletic Code of Conduct in addition to any school rules that may apply. It is imperative that any social media correspondences fall under the guidelines of sportsmanship and fair play. Please use good judgment when posting anything on one of these outlets. Those found in violation of the above will jeopardize participation in and/or attendance of an extracurricular event.

In addition, as a member of the athletic department in the Marple Newtown School District, I am expected to model our **"Six Pillars of Character"**: *hard work, sportsmanship, integrity, citizenship, respect and responsibility*. Any actions that would be contrary to those six pillars will jeopardize my participation in the athletic program.

I have read the above and agree to the terms discussed. I will strive to maintain "Tiger Pride" and display character in all aspects of my life as a student athlete in the Marple Newtown School District.

Print Student Name: _____ Sport: _____

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Marple Newtown School District Emergency Medical / Consent Form

Student's Name _____ Email: _____	
Grade _____	Date of Birth _____ Age _____ Sport: Boys/Girls- _____
Home Address: _____ Home # _____	
Parent/Guardian Contact # 1: _____ Relationship: _____	
Phone #: _____ Email: _____	
Parent/Guardian Contact # 2: _____ Relationship: _____	
Phone #: _____ Email: _____	
Emergency Contact <u>if parent/guardian cannot be reached</u> in an emergency situation.	
Emergency Contact # 1: _____ Relationship: _____	
Phone #: _____ Email: _____	
Emergency Contact # 2: _____ Relationship: _____	
Phone #: _____ Email: _____	
Family Physician: _____ Doctor's Phone #: _____	
Medical History/Medical Problems: _____	
Medications Currently Taking: _____	
Allergies to Medications: _____	
Family Insurance Company: _____ Policy Number: _____	
*** All Injuries should be reported to the coach/advisor and Certified Athletic Trainer. ***	
I hereby give permission to the attending Physician and or Certified Athletic Trainer at the athletic activities to carry out such emergency diagnostic and therapeutic procedures as may be necessary for my child.	
Signature of Parent/Guardian: _____ Date: _____	

Sports Injuries and Prescription Painkillers

Understanding Non-medical/Misuse of Prescription Medications

Prescription Medications

- The class of prescription drugs most commonly prescribed for pain is opioids, such as Vicodin, Percocet, Codeine, Demerol or Oxycontin. Under a doctor's orders, these medications can be very helpful. But if used improperly, they can be dangerous.
- Most individuals who misuse prescription medications, particularly teens, believe these substances are safer than illegal drugs because they are prescribed by a doctor. Doctors take into account things like the patient's age, weight, and medical history; the drug's form, dose, and possible side effects; and the potential for addiction, when prescribing medications.
- 70% of people 12 and older who abuse prescription drugs get them from family and friends, and 60% of teens who have abused prescription painkillers have done so before the age of 15.

What is Addiction?

- Addiction is a disease characterized by compulsive drug seeking behavior regardless of the consequences. As the illness progresses, an addicted person needs more of the drug, the illness becomes harder to treat, and the risk of overdose increases.
- Misusing medication can lead to serious consequences including addiction, other substance use, criminal activity, death.
- People who misuse painkillers might not understand how these factors interact and put them at risk for serious negative consequences. Additionally, mixing prescription opioids with alcohol or other drugs is the leading cause of overdose death in Delaware County.

It is important for parents/guardians to be aware of what substances your student athlete may be exposed to or using during the season. What are the signs and symptoms you should look for?

Signs of use

- Anxiety/Irritability
- Insomnia
- Long periods of sleep
- Loss of appetite/nausea
- Watery eyes
- Chills
- Depression
- Disorientation
- Pinpoint pupils

Signs of dependency

- Change in personality
- Social withdrawal
- Change in daily habits
- Neglect responsibilities
- Forgetfulness
- Increased sensitivity
- Change in appearance
- Receiving lower grades
- Increased absence

Signs of overdose*

**If you see any of these signs, consider this an emergency and call 911 immediately.*

- May not awaken when aroused
- Cold, clammy skin
- Blue lips, face, hands
- Struggle for breath
- Elevated body temperature
- Vomiting
- Behaving Irrationally/confused

Take Action! What can you do if your athlete is prescribed medication?

1. **Know** → Know what medications your athlete is using and the signs of use, dependency, and overdose.
2. **Monitor** → The adult in the household should maintain possession of the medication and closely monitor the dosage and refills. Although most youth are capable of self-administering over-the-counter painkillers, prescription opiates should be closely supervised by an adult. Set clear rules with your medications! Never share, take more than prescribed, or mix with other drugs.
3. **Talk** → Discuss the dangers of prescription medications with your athlete. Emphasize that just because they are prescribed by a doctor, it does not make them safe!
4. **Lock Your Meds** → Keep all prescription medications locked up to keep your family and friends safe! When the prescription is no longer needed, dispose of the unused medication at any Delaware County Drop Box locations (visit www.co.delaware.pa.us/heroin for locations).

I have reviewed and understand the symptoms and warning signs of prescription drug misuse.

Signature of Student-Athlete

Print Student-Athlete's Name

Date: ____/____/____

Signature of Parent/Guardian

Print Parent/Guardian's Name

Date: ____/____/____



Delaware County Council
THOMAS J. MCGARRIGLE
Chairman
MARIO J. CIVERA JR.

Vice Chairman

COLLEEN P. MORRONE
JOHN P. McBLAIN
DAVID J. WHITE

DELAWARE COUNTY HEROIN TASK FORCE

DELAWARE COUNTY GOVERNMENT CENTER
201 W. Front Street
Media, PA 19063

www.co.delaware.pa.us/heroin
(610) 891-4163



Delaware County
District Attorney
JOHN J. WHELAN

MNSD Activity Fee

The activity fee is to help offset the costs associated with identified school-sponsored and approved extracurriculars (listed below). The annual fee of \$100 per student, with a maximum of \$200 per family, entitles the student to participate in multiple activities. Students approved for free and reduced lunch are not required to pay the fee. The fee is determined based on the following criteria:

- The activity involves a supplemental employee contract such as a school district selected and compensated coach, advisor, director, or sponsor.
- The activity comprises MNSD students only.
- The activity involves MNSD students in either competitions and/or performances.

The fee must be paid by the first day of participation in an activity. It can be paid online through School Café or by check made out to "Marple Newtown School District." If you choose to pay by check, please either hand it to the coach, director/sponsor or deliver it to Susan Becker (High School) or Julie Rufo (Middle School). **Students will not be permitted to participate until the fee is paid.**

Meals for students are not funded through the activity fee or District funds.

Elective competitions, games, performances, or camps are not funded through the activity fee or District funds. Student participants are responsible for their own expenses for elective events.

For state and national club activities in which students qualify to compete, MNSD will contribute up to \$5,000 annually toward commercial club travel expenses, including registration, airfare, and lodging, that are directly related to competitions. The District will not fund lodging for events within a 100-mile radius.

Below is a current list of activities to which this fee apply. Please check all that you anticipate your child will participate in this year:

Clubs		Athletics				Performing Arts	
Annenberg	☐	Baseball	☐	Golf	☐	Indoor Percussion	☐
Debate Team	☐	Basketball	☐	Indoor Track	☐	Jazz Band	☐
FBLA	☐	Bocce	☐	Lacrosse	☐	Marching Band	☐
Forensics	☐	Cheer	☐	Soccer	☐	Musical/Theatre	☐
Hi-Q	☐	Cross Country	☐	Softball	☐	Paxon Hollow Band	☐
Math Club	☐	Diving/Swimming	☐	Tennis	☐	Paxon Hollow Choir	☐
Mock Trial	☐	Field Hockey	☐	Track & Field	☐	Paxon Hollow Orchestra	☐
Model UN	☐	Flag Football	☐	Volleyball	☐	Select Choir	☐
Reading Olympics	☐	Football	☐	Wrestling	☐	Winter Guard	☐
Science Olympiad	☐						

Student Name: _____

Grade: _____

Sibling(s) Name & Grade if also participating in an activity: _____

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

These symptoms can be unclear and confusing in athletes. Some may ignore the signs or think they are normal results of 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 ____/____/____
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		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							
☐ High blood pressure	☐	☐	31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐					
☐ Heart murmur	☐	☐	32. Have you been hit in the head and been confused or lost your memory?	☐	☐					
☐ High cholesterol	☐	☐	33. Do you experience dizziness and/or headaches with exercise?	☐	☐					
☐ Heart infection	☐	☐	34. Have you ever had a seizure?	☐	☐					
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	☐	☐	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐					
11. Has anyone in your family died for no apparent reason?	☐	☐	36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐					
12. Does anyone in your family have a heart problem?	☐	☐	37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐					
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	☐	☐	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐					
14. Does anyone in your family have Marfan Syndrome?	☐	☐	39. Have you had any problems with your eyes or vision?	☐	☐					
15. Have you ever spent the night in a hospital?	☐	☐	40. Do you wear glasses or contact lenses?	☐	☐					
16. Have you ever had surgery?	☐	☐	41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐					
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:	☐	☐	42. Are you unhappy with your weight?	☐	☐					
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐	43. Are you trying to gain or lose weight?	☐	☐					
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:	☐	☐	44. Has anyone recommended you change your weight or eating habits?	☐	☐					
Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/Fingers	Chest	45. Do you limit or carefully control what you eat?	☐	☐
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/Toes	46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
20. Have you ever had a stress fracture?	☐	☐	MENSTRUAL QUESTIONS- IF APPLICABLE			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?			49. How many periods have you had in the last 12 months?				
22. Do you regularly use a brace or assistive device?	☐	☐	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? | ☐ | ☐ |
|--|--------------------------|--------------------------|

- | | | |
|--|--------------------------|--------------------------|
| | 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.