



Greetings!

We are excited to announce that we are now offering the convenience of online registration through Arbiter Student Registration!

Arbiter Student Registration is a secure registration platform that provides you with an easy, user-friendly way to register for our programs, and helps us to be more administratively efficient and environmentally responsible. When you register through Arbiter Student Registration, the system keeps track of your information in your profile. You enter your information only once for each family member for multiple uses and multiple programs.

BEFORE YOU REGISTER:

Please be sure you have obtained a physical examination provided by a physician. Your physical **MUST** be completed on the PIAA Section 6 form. No other type of physical form (i.e PennDOT) will be accepted. To download a paper copy of this form, please visit: PIAA.org.

INFORMATION NEEDED TO REGISTER:

It will be helpful to have the following information handy to allow for the accurate completion of your online registration.

- Primary Care physician information
- Health Insurance Information and ID card (if applicable)

REGISTRATION PROCESS:

A parent/guardian can register by clicking on this link:

[Arbiter Student Registration - Winter 2026-2027](#)

Registering as a new user on Arbiter Student Registration is simple. Instructions on the next page:



Follow these steps:

First, create and activate your Arbiter Student Registration account.

1. If you have not already done so, [create an Arbiter Registration account here](#).
2. After you sign up for an account please check your inbox for an Activation Email from Arbiter Student Registration. You'll need to click the link in that email to activate your account.
3. Once you have activated your account, you will be ready to register for our program! [Please click here to read a help article on how to register for the first time](#).
4. Print out the completed [Student Activity Fee Form here](#) and submit it to the business office with payment.
5. Click the blue **Submit** button. After selecting **Submit**, the registration will be complete. You will receive a completion email from Arbiter confirming your registration and the registration will be submitted for approval by our Athletic Training Staff.
6. Families with multiple student-athletes: You DO NOT need to create separate accounts per student-athlete, simply choose "add participant" under the "participant information" section. **All student-athletes from the same household should be registered from the same account.**

At any time, you may log in to Arbiter Registration, *click Login*, and *click For Families/Students* at www.arbiter.io to update your information and to check your registration(s).

To view a completed registration, select the **Registrations** tab in the blue menu bar at the top of your screen.

Support:

If you need assistance with registration, contact Arbiter at: support@arbitersports.com or 800-311-4060. Phone support is available Monday through Friday 6 AM – 5PM MST, Saturday 8 AM – 4PM MST* and Sundays 10 AM – 6PMMST*

**Saturday and Sunday phone hours are for Arbiter Registration calls only. All other support issues are supported via email.*

SECTION 5: HEALTH HISTORY

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

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	☐	☐	23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
2. Do you have an ongoing medical condition (like asthma or diabetes)?	☐	☐	24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐	25. Is there anyone in your family who has asthma?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐	26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐	28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐	30. Have you ever had a herpes skin infection?	☐	☐
9. Has a doctor ever told you that you have (check all that apply):			CONCUSSION OR TRAUMATIC BRAIN INJURY 31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? ☐ ☐ 32. Have you been hit in the head and been confused or lost your memory? ☐ ☐ 33. Do you experience dizziness and/or headaches with exercise? ☐ ☐ 34. Have you ever had a seizure? ☐ ☐ 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ☐ ☐ 36. Have you ever been unable to move your arms or legs after being hit or falling? ☐ ☐ 37. When exercising in the heat, do you have severe muscle cramps or become ill? ☐ ☐ 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ☐ ☐ 39. Have you had any problems with your eyes or vision? ☐ ☐ 40. Do you wear glasses or contact lenses? ☐ ☐ 41. Do you wear protective eyewear, such as goggles or a face shield? ☐ ☐ 42. Are you unhappy with your weight? ☐ ☐ 43. Are you trying to gain or lose weight? ☐ ☐ 44. Has anyone recommended you change your weight or eating habits? ☐ ☐ 45. Do you limit or carefully control what you eat? ☐ ☐ 46. Do you have any concerns that you would like to discuss with a doctor? ☐ ☐ MENSTRUAL QUESTIONS- IF APPLICABLE ☐ ☐ 47. Have you ever had a menstrual period? ☐ ☐ 48. How old were you when you had your first menstrual period? _____ 49. How many periods have you had in the last 12 months? _____ 50. When was your last menstrual period? _____		
☐ 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 Ankle Chest					
Upper back Lower back Hip Thigh Knee Calf/shin Foot/ Toes					
20. Have you ever had a stress fracture?	☐	☐			
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐			
22. Do you regularly use a brace or assistive device?	☐	☐			

#s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date ____/____/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date ____/____/____

Sección 5: Historial de salud

Explique las respuestas "Sí" al final de este formulario. Encierre en un círculo las preguntas cuya respuesta no sepa.

	Sí	No		Sí	No
1. ¿Alguna vez un médico le ha negado o restringido su participación en deportes por algún motivo?	☐	☐	23. ¿Alguna vez un médico le ha dicho que tiene asma o alergias?	☐	☐
2. ¿Tiene una condición médica en curso (como asma o diabetes)?	☐	☐	24. ¿Tose, resuena o tiene dificultad para respirar DURANTE o DESPUÉS del ejercicio?	☐	☐
3. ¿Está tomando actualmente algún medicamento o píldora con o sin receta (de venta libre)?	☐	☐	25. ¿Hay alguien en su familia que tenga asma?	☐	☐
4. ¿Tiene alergia a medicamentos, polen, alimentos o picaduras de insectos?	☐	☐	26. ¿Alguna vez usó un inhalador o tomó medicamentos para el asma?	☐	☐
5. ¿Alguna vez se desmayó o estuvo a punto de desmayarse DURANTE el ejercicio?	☐	☐	27. ¿Nació sin o le falta un riñón, un ojo, un testículo o cualquier otro órgano?	☐	☐
6. ¿Alguna vez se ha desmayado o casi se ha desmayado DESPUÉS del ejercicio?	☐	☐	28. ¿Ha tenido mononucleosis infecciosa (mono) en el último mes?	☐	☐
7. ¿Alguna vez ha tenido molestias, dolor o presión en el pecho durante el ejercicio?	☐	☐	29. ¿Tiene erupciones, úlceras por presión u otros problemas de la piel?	☐	☐
8. ¿Su corazón se acelera o salta latidos durante el ejercicio?	☐	☐	30. ¿Ha tenido alguna vez una infección cutánea por herpes?	☐	☐
9. ¿Alguna vez le ha dicho un médico que tiene (marque todo lo que corresponda):	☐	☐	31. ¿Alguna vez ha tenido una conmoción cerebral (es decir, un timbre, un tintineo, un golpe en la cabeza) o una lesión cerebral traumática?	☐	☐
Alta presión sanguínea	☐	☐	32. ¿Le han golpeado en la cabeza y ha estado confundido o ha perdido la memoria?	☐	☐
Soplo cardíaco	☐	☐	33. ¿Experimenta mareos y / o dolores de cabeza con el ejercicio?	☐	☐
Colesterol alto	☐	☐	34. ¿Ha tenido convulsiones alguna vez?	☐	☐
Infección del corazón	☐	☐	35. ¿Alguna vez ha tenido entumecimiento, hormigueo o debilidad en los brazos o piernas después de haber sido golpeado o caído?	☐	☐
10. ¿Alguna vez un médico ordenó una prueba para su corazón? (por ejemplo, ECG, ecocardiograma)	☐	☐	36. ¿Alguna vez no ha podido mover los brazos o las piernas después de un golpe o una caída?	☐	☐
11. ¿Ha muerto alguien de su familia sin motivo aparente?	☐	☐	37. Cuando hace ejercicio en el calor, ¿tiene calambres musculares graves o se enferma?	☐	☐
12. ¿Alguien de su familia tiene un problema cardíaco?	☐	☐	38. ¿Le ha dicho un médico que usted o alguien de su familia tiene el rasgo de anemia falciformes o la enfermedad de anemia falciformes?	☐	☐
13. ¿Algún miembro de la familia o pariente ha sido discapacitado debido a una enfermedad cardíaca o ha muerto de problemas cardíacos o muerte súbita antes de los 50 años?	☐	☐	39. ¿Ha tenido algún problema con sus ojos o visión?	☐	☐
14. ¿Alguien en su familia tiene síndrome de Marfan?	☐	☐	40. ¿Usa anteojos o lentes de contacto?	☐	☐
15. ¿Ha pasado alguna vez la noche en un hospital?	☐	☐	41. ¿Utiliza anteojos protectores, como gafas protectoras o un protector facial?	☐	☐
16. ¿Alguna vez se ha tenido a una cirugía?	☐	☐	42. ¿No estás contenta(o) con tu peso?	☐	☐
17. ¿Alguna vez ha tenido una lesión, como un esguince, desgarro de un músculo o ligamento, o tendinitis, que le hizo perder una práctica o un concurso? En caso afirmativo, marque con un círculo el área afectada a continuación:	☐	☐	43. ¿Estás tratando de ganar o perder peso?	☐	☐
18. ¿Ha tenido huesos rotos o fracturados o articulaciones dislocadas? En caso afirmativo, marque con un círculo a continuación:	☐	☐	44. ¿Alguien le ha recomendado que cambie su peso o sus hábitos alimenticios?	☐	☐
19. ¿Ha tenido una lesión en los huesos o articulaciones que requirió radiografías, resonancia magnética, tomografía computarizada, cirugía, inyecciones, rehabilitación, fisioterapia, un aparato ortopédico, yeso o muletas? En caso afirmativo, marque con un círculo a continuación:	☐	☐	45. ¿Limita o controla cuidadosamente lo que come?	☐	☐
<div style="display: flex; justify-content: space-between; padding: 0;"> Cabeza Cuello Hombro Brazo Codo Mano / Dedos Pecho </div> <div style="display: flex; justify-content: space-between; padding: 0;"> Superior de la espalda Espalda baja Cadera Muslo Rodilla Tobillo Pie </div>			46. ¿Tiene alguna inquietud que le gustaría discutir con un médico?	☐	☐
20. ¿Alguna vez ha tenido una fractura por estrés?	☐	☐	Preguntas sobre la menstruación: si corresponde		
21. ¿Le han dicho que tiene o ha tenido una radiografía por inestabilidad atlantoaxial (cuello)?	☐	☐	47. ¿Alguna vez ha tenido un período menstrual?	☐	☐
22. ¿Utiliza habitualmente un aparato ortopédico o de ayuda?	☐	☐	48. ¿Qué edad tenías cuando tuviste tu primer período menstrual?	☐	☐
			49. ¿Cuántos períodos ha tenido en los últimos 12 meses?	☐	☐
			50. ¿Cuándo fue su última menstruación?	☐	☐

#'s	Explicar "Sí", responde aquí:

Por la presente certifico que, a mi leal saber y entender, toda la información contenida en este documento es verdadera y completa.

Firma del estudiante _____ **Fecha** ____ / ____ / ____

Por la presente Certifico aquí que, a mi leal saber y entender, toda la información contenida en este documento es verdadera y completa.

Firma del padre / guardian _____ **Fecha** ____ / ____ / ____

**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 ____/____/____