**UC 2021-2022 FALL SPORTS PHYSICALS: August 5th**

Dear Parents and/or Guardians:

Athletic physicals are Thursday, August 5th at the Union City Area Elementary School for the Fall 2021-2022 athletic season.

**These physicals will cost $10 and are required of any student who wishes to participate in a middle or high school PIAA sport.**

Please read all of the [physical packet forms](https://www.pinerichland.org/cms/lib/PA01001138/Centricity/Domain/1160/finalphysicalpacke2018_2019.pdf) carefully.  Follow all directions and fill in the forms completely. **Parents/Guardians must fill out, read and/or sign on “Sections 1- Section 6” in the packet. Section 7 of this packet must be filled out by a** **physician.**

**Students must bring these signed forms and $10 cash or check (checks made payable to Union City Area School District) at the assigned time for your child’s sport. (see following page)**

**Allegheny Health Network and Saint Vincent’s Consent to Treat and HIPAA forms** must also be signed.  Union City Area School District contracts athletic training services through AHN Sports Medicine.  These forms are required by the athletic training staff.

You may choose to have your student’s sports physical exam conducted at your private physician’s office.  **THE EXAM CANNOT HAVE TAKEN PLACE PRIOR TO JUNE 1, 2021.**This is a PIAA state rule.  The physician must fill out **“Section 7”**of this packet, and you must turn in the entire completed packet by **August 9, 2021**, if participating in a fall sport.  **Your student will not be** **allowed to try out or practice without a current completed physical packet on file.**

**All sports physical exams must be completed using the PIAA CIPPE forms in this packet.  Other physical exam forms will not be accepted.**

If you have any questions please email me: [ndesimone@ucasd.org](mailto:ndesimone@ucasd.org) or call 814-790-2297.

Sincerely,

Nathan DeSimone

Athletic Director

**Union City Athletic Physicals: August 5, 2021**

Please follow this time schedule and bring your packets signed and filled out.

9:00-9:15          BOYS AND GIRLS GOLF

9:15-9:30        BOYS AND GIRLS CROSS COUNTRY (Junior High, JV, and Varsity)

9:30-10:00        VOLLEYBALL (JV, and Varsity)

10:00-10:30      FOOTBALL (Junior High, JV, and Varsity)

10:30-11:00 GIRLS BASKETBALL (Junior High)

11:00-11:30    FOOTBALL CHEERLEADERS



Dear Parent/Guardian:

As part of the contractual agreement between Allegheny Health Network (AHN) and your child’s school, AHN provides certified athletic trainers and clinicians to aid in the prevention, evaluation and treatment of injuries that occur as part of your child’s participation in athletic programs.

In order to treat your child’s injuries, two forms must be signed by both the parent/guardian and the student athlete.

1. The ***Consent to Treatment,* Form,** which gives the certified athletic trainer(s) and/or clinician(s) permission to provide care in the event of a sports-related injury/illness.

2. The ***HIPAA Authorization for Release of Protected Health Information* Form,** which allows the athletic trainer(s) and/or clinician(s) to communicate with the school’s athletic department staff, coaches, other school administrators, EMS companies, and other involved parties regarding a student athlete and his or her injury/illness.

Please note that these forms have no relationship to your health insurance plan and in no way influence your choice of medical care; AHN needs these forms signed to be able to provide care and comply with legal and regulatory standards.

A copy of AHN’s Notice of Privacy Practices can be viewed here:

<https://www.ahn.org/notice-of-privacy-practices>

If you decide to revoke the Authorization or Consent to Treatment forms, please contact the school's athletic office.

Sincerely,

Allegheny Health Network Sports Medicine



Patient Name: \_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: (xx/xx/xxxx):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 (Four) digits of SSN: \_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Release of Protected Health Information**

I hereby authorize the Allegheny Health Network (AHN) certified athletic trainer(s) and team clinician(s) to release Protected

Health Information (PHI) to: school athletic department staff, coaches, other school administrators, EMS personnel, and other persons/entities involved in school athletics for the purpose of establishing and delivering a treatment plan or determining if a

student athlete qualifies for participation in school-sponsored sports activities.

The PHI I would like to have released is as follows:

⬜ Release my entire chart (I understand this may include information pertaining to AIDS/HIV; mental health care; treatment for alcohol and/or drug abuse; and sexually transmitted disease).

**Do not release: ⬜ AIDS/HIV ⬜ Mental Health History ⬜ Drug & Alcohol**

⬜ Other (specifically identify exact information to be disclosed, including specific dates of service):  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I understand that this Authorization shall expire one (1) year from the date of signature unless otherwise specified.
* I understand that this Authorization will remain in effect if I am treated for an injury during off-season workouts within the calendar year of when I signed the Authorization.
* I understand that I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to AHN. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization.
* I understand that I am not required to sign this Authorization as condition of my obtaining treatment.
* I understand that, to extent that any recipient of this information is not a “covered entity” under HIPAA, the information may no longer be protected by law. I understand that, in these circumstances, the individual receiving this information may be permitted to re-disclose the information. I understand that my healthcare provider is not responsible should the individual receiving this information re-disclose the information.
* I am entitled to a copy of this completed Authorization upon my request.
* I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  
**Signature of Patient/Student Athlete** Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  
**Signature of Parent, Legal Guardian or Personal Representative** Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  
Witness/Staff Member Signature Date

If signed by a Personal Representative, complete the following:

Printed Name of Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Description of authority to act for individual (include supporting documentation): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Treatment by Certified Athletic Trainer(s)/Team Clinician(s)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (printed name of parent, legally authorized representative, or student athlete, if over 18) hereby authorize Allegheny Health Network (AHN) Certified Athletic Trainer(s)/Team Clinician(s) to provide injury/illness care and prevention related to participation in student athletic programs.

I understand that others may assist or participate in providing care and establishing treatment regimens. Under the direction/supervision of a certified athletic trainer or team clinician, athletic training students and high school student aides may also assist in furnishing care.

This consent is valid for one (1) year from the date below unless otherwise specified.

I understand that this consent is subject to revocation at any time, except to the extent that AHN has already taken action in reliance upon it. A photocopy or facsimile of this consent will be considered valid

I understand that AHN’s Notice of Privacy Practices can be reviewed here: <https://www.ahn.org/notice-of-privacy-practices>

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent, Guardian, or Student Athlete (if over 18) Signature Date Witness**

 Union City Area School District

105 Concord Street

Union City, PA 16438

Phone: (814) 438-7673

Fax: (814) 438-8079

**EXTRA CURRICULAR PARENT PERMISSION/RELEASE**

We, the parents/guardians of , request that this notice allow our child to be released to us, when requested, upon completion of away events. It is understood that all responsibility for safe transport home is returned to the parents/guardians. This agreement is valid for the following \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_season only, and must be updated

(Sport)

each athletic/event season.

It is understood that a copy of this signed agreement will be on file in the MS/HS Office. In addition, copies will be given to both the student’s parents and coach.

**THE FOLLOWING PARENTS/GUARDIANS ARE AUTHORIZED TO TAKE THEIR CHILD HOME FROM AWAY ATHLETIC/PERFORMANCE EVENTS DURING THE DESIGNATED SEASON.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Principal/Athletic Director 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 seven Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, 5 and 6 by the student and parent/guardian; and Section 7 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal’s designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st or the conclusion of the spring sports season.**

**SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 8 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 9 need be completed.**

**SECTION 1: PERSONAL AND EMERGENCY INFORMATION**

**PERSONAL INFORMATION**

Student’s Name Male/Female (circle one)

Date of Student’s Birth: \_/\_ /\_

Age of Student on Last Birthday:

Grade for Current School Year:

Current Physical Address

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

Fall Sport(s): Winter Sport(s): Spring Sport(s):

**EMERGENCY INFORMATION**

Parent’s/Guardian’s Name Relationship

Address Emergency Contact Telephone # ( )

Secondary Emergency Contact Person’s Name Relationship

Address Emergency Contact Telephone # ( )

Medical Insurance Carrier Policy Number

Address Telephone # ( )

Family Physician’s Name , MD or DO (circle one)

Address Telephone # ( )

Student’s Allergies

Student’s Health Condition(s) of Which an Emergency Physician or Other Medical Personnel Should be Aware

Student’s Prescription Medications and conditions of which they are being prescribed

**Revised: April 27, 2021 BOD approved**

**SECTION 2: CERTIFICATION OF PARENT/GUARDIAN**

**The student’s parent/guardian must complete all parts of this form.**

**A.** I hereby give my consent for born on who turned on his/her last birthday, a student of School and a resident of the public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20 - 20\_ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

|  |  |
| --- | --- |
| **Winter**  **Sports** | **Signature of Parent or Guardian** |
| Varsity Boys/Girls  Basketball |  |
| JH  Boys Basketball |  |
| Swimming and Diving |  |
| Varsity  Wrestling |  |
| JH Wrestling |  |
| Varsity Cheerleading |  |
| JH Cheerleading |  |

|  |  |
| --- | --- |
| **Spring**  **Sports** | **Signature of Parent or Guardian** |
| Varsity Baseball |  |
| Varsity Softball |  |
| Varsity Track & Field |  |
| JH Track & Field |  |
| JH Girls Volleyball |  |

|  |  |
| --- | --- |
| **Fall**  **Sports** | **Signature of Parent or Guardian** |
| Cross  Country |  |
| Varsity  Football |  |
| JH Football |  |
| Golf |  |
| Girls’  Volleyball |  |
| JH Girls  Basketball |  |

**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,](http://www.piaa.org/) include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent’s/Guardian’s Signature Date\_ / \_/\_

**C. Disclosure of records needed to determine eligibility:** To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

Parent’s/Guardian’s Signature Date\_ / \_/\_

**D. Permission to use name, likeness, and athletic information:** I consent to PIAA’s use of the herein named student’s name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent’s/Guardian’s Signature Date\_ / \_/\_

**E. Permission to administer emergency medical care:** I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians’ and/or surgeons’ fees, hospital charges, and related expenses for such emergency medical ca re. I further give permission to the school’s athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 7 regarding a medical condition or injury to the herein named student.

Parent’s/Guardian’s Signature Date\_ / \_/\_

**F. Confidentiality:** The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school’s athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).

Parent’s/Guardian’s Signature Date\_ /\_ \_/

**SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY**

**What is a concussion?**

A concussion is a brain injury that:

• Is caused by a bump, blow, or jolt to the head or body.

• Can change the way a student’s brain normally works.

• Can occur during Practices and/or Contests in any sport.

• Can happen even if a student has not lost consciousness.

• Can be serious even if a student has just been “dinged” or “had their bell rung.”

All concussions are serious. A concussion can affect a student’s ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student’s brain time to heal.

**What are the symptoms of a concussion?**

Concussions cannot be seen; however, in a potentially concussed student, ***one or more*** of the symptoms listed below may become apparent and/or that the student “doesn’t feel right” soon after, a few days after, or even weeks after the injury.

• Headache or “pressure” in head

• Nausea or vomiting

• Balance problems or dizziness

• Double or blurry vision

• Bothered by light or noise

• Feeling sluggish, hazy, foggy, or groggy

• Difficulty paying attention

• Memory problems

• Confusion

**What should students do if they believe that they or someone else may have a concussion?**

• **Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.

• **The student should be evaluated.** A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.

• **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student’s brain needs time to heal. While a concussed student’s brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student’s brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

**How can students prevent a concussion?** Every sport is different, but there are steps students can take to protect themselves.

• Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:

The right equipment for the sport, position, or activity; Worn correctly and the correct size and fit; and

Used every time the student Practices and/or competes.

• Follow the Coach’s rules for safety and the rules of the sport.

• Practice good sportsmanship at all times.

**If a student believes they may have a concussion:** Don’t hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student’s Signature Date /\_ /

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent’s/Guardian’s Signature Date /\_ /\_

**SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS**

**What is sudden cardiac arrest?**

Sudden cardiac arrest (SCA) occurs when the heart suddenly and unexpectedly stops beating. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart’s electrical system, causing the heart to suddenly stop beating.

**How common is sudden cardiac arrest in the United States?**

There are about 350,000 cardiac arrests that occur outside of hospitals each year. More than 10,000 individuals under the age of 25 die of SCA each year. SCA is the number one killer of student athletes and the leading cause of death on school campuses.

**Are there warning signs?**

Although SCA happens unexpectedly, some people may have signs or symptoms, such as

|  |  |
| --- | --- |
| • Dizziness or lightheadedness when exercising; | • 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 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 d ie 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 act ivity. 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

Signature of Parent/Guardian Print Parent/Guardian’s Name

Date /\_ /\_

Date /\_ /\_

PA Department of Health/CDC: Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet Acknowledgement of

Receipt and Review Form. 7/2012 PIAA Revised October 28, 2020

**Section 5: SUPPLEMENTAL ACKNOWLEDGEMENT, WAIVER AND RELEASE: COVID-19**

The COVID-19 pandemic presents athletes with a myriad of challenges concerning this highly contagious illness. Some severe outcomes have been reported in children, and even a child with a mild or even asymptomatic case of COVID -19 can spread the infection to others who may be far more vulnerable.

While it is not possible to eliminate all risk of being infected with or furthering the spread of COVID-19, PIAA has urged all member schools to take necessary precautions and comply with guidelines from the federal, state, and local governments, the CDC and the PA Departments of Health and Education to reduce the risks to athletes, coaches, and their families. As knowledge regarding COVI D-19 is constantly changing, PIAA reserves the right to adjust and implement precautionary methods as necessary to decrease the risk of exposure to athletes, coaches and other involved persons. Additionally, each school has been required to adopt internal prot ocols to reduce the risk of transmission.

The undersigned acknowledge that they are aware of the highly contagious nature of COVID-19 and the risks that they may be exposed to or contract COVID-19 or other communicable diseases by permitting the undersigned student to participate in interscholastic athletics. We understand and acknowledge that such exposure or infection may result in serious illness, personal injury, permanent disability or death. We acknowledge that this risk may result from or be compounded by the actions, omissi ons, or negligence of others. The undersigned further acknowledge that certain vulnerable individuals may have greater health risks associated with exposure to COVID-19, including individuals with serious underlying health conditions such as, but not limited to: high blood pressure, chronic lung disease, diabetes, asthma, and those whose immune systems that are compromised by chemotherapy for cancer, and other conditions requiring such therapy. While particular recommendations and personal discipline may reduce the risks associated with participating in athletics during the COVID-19 pandemic, these risks do exist. Additionally, persons with COVID-19 may transmit the disease to others who may be at higher risk of severe complications.

By signing this form, the undersigned acknowledge, after having undertaken to review and understand both symptoms and possible consequences of infection, that we understand that participation in interscholastic athletics during the COVID-19 pandemic is strictly voluntary and that we agree that the undersigned student may participate in such interscholastic athletics. The undersigned also understand that student participants will, in the course of competition, interact with and likely have contact with athletes from their own, as well as other, schools, including schools from other areas of the Commonwealth. Moreover, they understand and acknowledge that our school, PIAA and its member schools cannot guarantee that transmission will not occur for those particip ating in interscholastic athletics.

NOTWITHSTANDING THE RISKS ASSOCIATED WITH COVID-19, WE ACKNOWLEDGE THAT WE ARE VOLUNTARILY ALLOWING STUDENT TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS WITH KNOWLEDGE OF THE DANGER INVOLVED. WE HEREBY AGREE TO ACCEPT AND ASSUME ALL RISKS OF PERSONAL INJURY, ILLNESS, DISABILITY AND/OR DEATH RELATED TO COVID-19, ARISING FROM SUCH PARTICIPATION, WHETHER CAUSED BY THE NEGLIGENCE OF PIAA OR OTHERWISE.

We hereby expressly waive and release any and all claims, now known or hereafter known, against the studen t’s school, PIAA, and its officers, directors, employees, agents, members, successors, and assigns (collectively, "**Releasees**"), on account of injury, illness, disability, death, or property damage arising out of or attributable to Student’s participation in interscholastic athletics and being exposed to or contracting COVID-19, whether arising out of the negligence of PIAA or any Releasees or otherwise. We covenant not to make or bring any such claim against PIAA or any other Releasee, and forever release and discharge PIAA and all other Releasees from liability under such claims.

Additionally, we shall defend, indemnify, and hold harmless the student’s school, PIAA and all other Releasees against any and all losses, damages, liabilities, deficiencies, claims, actions, judgments, settlements, interest, awards, penalties, fines, costs, or expenses of whatever kind, including attorney fees, fees, and the costs of enforcing any right to indemnification and the cost of purs uing any insurance providers, incurred by/awarded against the student’s school, PIAA or any other Releasees in a final judgment arising out or resulting from any claim by, or on behalf of, any of us related to COVID-19.

We willingly agree to comply with the stated guidelines put forth by the student’s school and PIAA to limit the exposure and spread of COVID-19 and other communicable diseases. We certify that the student is, to the best of our knowledge, in good physical condition and allow participation in this sport at our own risk. By signing this Supplement, we acknowledge that we have received and reviewed the student’s school athletic plan.

Date:

Signature of Student Print Student’s Name

Signature of Parent/Guardian Print Parent/Guardian's Name

Revised – October 7, 2020

Student’s Name Age Grade

**SECTION 6: 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

23. Has a doctor ever told you that you have

Yes No

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,

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?

❑ ❑

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

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

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

(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

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?

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

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:

❑ ❑

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?

❑ ❑

Upper

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Head | Neck | Shoulder | Upper | Elbow | Forearm | Hand/ | Chest |
|  |  |  | arm |  |  | Fingers |  |

back

Lower

back

Hip Thigh Knee Calf/shin Ankle Foot/

Toes

46. Do you have any concerns that you would

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? ❑ ❑

like to discuss with a doctor? ❑ ❑

**FEMALES ONLY** ❑ ❑

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. Are you pregnant? ❑ ❑

|  |  |
| --- | --- |
| **#’s** | **Explain “Yes” answers here:** |
|  |  |
|  |  |
|  |  |

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

Student’s Signature Date / /

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

Parent’s/Guardian’s Signature Date /\_ /\_

**SECTION 7: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER**

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student’s comprehensive

initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal’s designee, of the student's school.

Student’s Name Age Grade Enrolled in School Sport(s)

Height\_ Weight\_ % Body Fat (optional) Brachial Artery BP /\_ (\_ / , /\_ ) RP\_

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student’s

primary care physician is recommended.

**Age 10-12:** BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/\_ L 20/\_

Corrected: YES NO (circle one) Pupils: Equal Unequal

|  |  |  |
| --- | --- | --- |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance |  |  |
| Eyes/Ears/Nose/Throat |  |  |
| Hearing |  |  |
| Lymph Nodes |  |  |
| Cardiovascular |  | ❑ Heart murmur ❑ Femoral pulses to exclude aortic coarctation  ❑ Physical stigmata of Marfan syndrome |
| Cardiopulmonary |  |  |
| Lungs |  |  |
| Abdomen |  |  |
| Genitourinary (males only) |  |  |
| Neurological |  |  |
| Skin |  |  |
| **MUSCULOSKELETAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Neck |  |  |
| Back |  |  |
| Shoulder/Arm |  |  |
| Elbow/Forearm |  |  |
| Wrist/Hand/Fingers |  |  |
| Hip/Thigh |  |  |
| Knee |  |  |
| Leg/Ankle |  |  |
| Foot/Toes |  |  |

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student’s HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to

by the student’s parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

❑ **CLEARED** ❑ **CLEARED** with recommendation(s) for further evaluation or treatment for:

❑ **NOT CLEARED** for the following types of sports (please check those that apply):

❑ COLLISION ❑ CONTACT ❑ NON-CONTACT ❑ STRENUOUS ❑ MODERATELY STRENUOUS ❑ NON-STRENUOUS

Due to

Recommendation(s)/Referral(s)

AME’s Name (print/type) License # Address Phone ( )

AME’s Signature MD, DO, PAC, CRNP, or SNP *(circle one)* Certification Date of CIPPE / /\_

**SECTION 8: 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 9, 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)

Date of Student’s Birth: /\_ /

Age of Student on Last Birthday:

Grade for Current 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

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 9, 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

3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or

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? ❑ ❑

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 9: 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 6 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 9 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 6 and 7 of the herein named student's previously completed CIPPE Form. Section 8 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 8.**

**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

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 10: 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 Grav ity/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 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 \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Percent 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 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.