UC 2020-2021 FALL SPORTS PHYSICALS – JULY 16TH

Dear Parents and/or Guardians:

Athletic physicals are Thursday, July 16th at the Union City Area Elementary School for the Fall 2020-2021 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 carefully. Follow all directions and fill in the forms completely. **Parents/Guardians must fill out, read and/or sign on "Sections 1-Section 5" in the packet. Section 6 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, 2020.** This is a PIAA state rule. The physician must fill out **"Section 6"** of this packet, and you must turn in the entire completed packet by **August 10, 2020**, 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 or call 814-790-2297.

Sincerely,

Nathan DeSimone

Athletic Director

Union City Athletic Physicals: July 16th 2020

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

Allegheny Health Network

Sports Medicine

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

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**

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 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 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)

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 _____

_____

SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

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

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

Fall Sports	Signature of Parent or Guardian
Varsity/Jr. High Cross Country	
Varsity Girls' Volleyball	
Varsity/ Jr. High Football	
Varsity Golf	
Varsity Football Cheerleading	
Jr. High Girls' Basketball	

Winter Sports	Signature of Parent or Guardian
Varsity Basketball	
Varsity/Jr. High Wrestling	
Varsity Basketball Cheerleading	
Varsity Wrestling Cheerleading	
Jr. High Cheerleading	
Swimming and Diving	
Jr. High Boys Basketball	

Spring Sports	Signature of Parent or Guardian
Varsity Baseball	
Varsity Softball	
Varsity Track & Field (Outdoor)	
Jr. High Girls' Volleyball	
Jr. High Track & Field (Outdoors)	

B. Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

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

C. Disclosure of records needed to determine eligibility: 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 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 6 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) is when the heart stops beating, suddenly and unexpectedly. 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 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

Are there warning signs?

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

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, 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 have SCA die from it.

Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

Information about SCA symptoms and warning signs.

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may *also* hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

Removal from play/return to play

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. 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 and understand the symptoms and warning signs of SCA.

_____ _____ Date____/___/_____

Signature of Student-Athlete | Print Student-Athlete's Name

_____ _____ Date____/___/_____

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

Student's Name _____ Age_____ Grade_____

SECTION 5: HEALTH HISTORY

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

	Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	☐	☐
2. Do you have an ongoing medical condition (like asthma or diabetes)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply):		
☐ High blood pressure ☐ Heart murmur		
☐ High cholesterol ☐ Heart infection		
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:		
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:		
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:		
Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest		
Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes		
20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐

	Yes	No
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you ever had a herpes skin infection?	☐	☐
CONCUSSION OR TRAUMATIC BRAIN INJURY		
31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?		
32. Have you been hit in the head and been confused or lost your memory?		
33. Do you experience dizziness and/or headaches with exercise?	☐	☐
34. Have you ever had a seizure?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you unhappy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
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 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_____

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)

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 # ( )_____

SUPPLEMENTAL HEALTH HISTORY:

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 an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic medicine?	☐	☐
2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?	☐	☐
4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	☐	☐
5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills?	☐	☐
6. Do you have any concerns that you would like to discuss with a physician?	☐	☐

#'s	Explain "Yes" answers 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 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 6 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_____

Enrolled in _____School

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

_____

_____

_____

_____

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

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

Address_____Phone ( )_____

Physician's Signature _____MD or DO *(circle one)* Date_____

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

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

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

Address_____ Phone ( )_____

Physician's Signature _____MD or DO *(circle one)* Date_____

Section 9: CIPPE MINIMUM WRESTLING WEIGHT

INSTRUCTIONS

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

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

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

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

Student's Name _____ Age_____ Grade

Enrolled in _____ School

INITIAL ASSESSMENT

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

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

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

Assessor's Signature_____Date____/____/_____

CERTIFICATION

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

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

Address_____ Phone ( )_____

AME's Signature_____MD, DO, PAC, CRNP, or SNP 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.