SCHOOL DISTRICT OF PITTSBURGH

STUDENT SERVICES
OFFICES OF INTERSCHOLASTIC ATHLETICS AND HEALTH SERVICES

PARENT PERMISSION FOR COMPLETION OF ATHLETIC PHYSICAL

Please sign this form if you want your child’s sports physical to be completed by the school district’s nurse practitioner or school physician.

I request that the school nurse practitioner or the school physician complete my child’s pre-participation physical including any required recertification physicals during the school year.

Signature of Parent/Guardian

Date

NOTE: YOUR CHILD SHOULD RETURN THE SIGNED FORM TO THE SCHOOL FACULTY MANAGER.
SCHOOL DISTRICT OF PITTSBURGH

STUDENT SERVICES
OFFICES OF INTERSCHOLASTIC ATHLETICS AND HEALTH SERVICES

PARENTAL STATEMENT OF TRUTH

I hereby certify that the information supplied herein is true and correct to the best of my knowledge, information and belief. I understand that any false statements are subject to penalties for false verification under the Laws of Pennsylvania. I further certify that I understand that the School District of Pittsburgh is relying upon the truth and accuracy of the information contained herein and in reliance thereon, is permitting my minor child to participate in interscholastic athletics. I further understand that in the event of false or erroneous information on the form, the privilege of participation may be withdrawn.

Student’s Name [please print]

Parent/Guardian Signature

Date

STEROID USE PROHIBITION

I, the undersigned parent or guardian, and I, the undersigned student, understand the use of anabolic steroids by any student involved in school-related athletics is prohibited, except for a valid medical purpose. We understand that bodybuilding, muscle enhancement, increased muscle bulk or strength, or the enhancement of athletic ability is not a medical purpose. We further understand that the student may be subject to random and specific testing for anabolic steroid use before and during the athletic season(s). We are aware that the use of anabolic steroids may, at least, result in the temporary or permanent suspension from school athletics as specified by the Board of Public Education.

Parent’s Signature

Date

Student’s Signature

Date
PIAA COMPREHENSIVE INITIAL
PRE-PARTICIPATION PHYSICAL EVALUATION

INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal’s designee, of the student’s school for retention by the school. The CIPPE may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the next May 31st.

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 Should be Aware

___________________________________________________________
___________________________________________________________
___________________________________________________________
Student’s Prescription Medications

___________________________________________________________
___________________________________________________________
___________________________________________________________

Revised: March 22, 2013
**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 __________________, 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.

<table>
<thead>
<tr>
<th>Fall Sports</th>
<th>Signature of Parent or Guardian</th>
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<tbody>
<tr>
<td>Cross</td>
<td></td>
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<tr>
<td>Country</td>
<td></td>
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<tr>
<td>Field Hockey</td>
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<td>Football</td>
<td></td>
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<tr>
<td>Golf</td>
<td></td>
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<tr>
<td>Soccer</td>
<td></td>
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<tr>
<td>Girls’ Tennis</td>
<td></td>
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<tr>
<td>Girls’ Volleyball</td>
<td></td>
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<tr>
<td>Water Polo</td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Winter Sports</th>
<th>Signature of Parent or Guardian</th>
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<tbody>
<tr>
<td>Basketball</td>
<td></td>
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<tr>
<td>Bowling</td>
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<tr>
<td>Competitive Spirit Squad</td>
<td></td>
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<tr>
<td>Girls’ Gymnastics</td>
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<tr>
<td>Rifle</td>
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<tr>
<td>Swimming and Diving</td>
<td></td>
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<tr>
<td>Track &amp; Field (Indoor)</td>
<td></td>
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<tr>
<td>Wrestling</td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Spring Sports</th>
<th>Signature of Parent or Guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseball</td>
<td></td>
</tr>
<tr>
<td>Boys’ Lacrosse</td>
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<tr>
<td>Girls’ Lacrosse</td>
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<tr>
<td>Softball</td>
<td></td>
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<tr>
<td>Boys’ Tennis</td>
<td></td>
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<tr>
<td>Track &amp; Field (Outdoor)</td>
<td></td>
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<tr>
<td>Boys’ Volleyball</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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 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 hospitalized, 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.

Parent’s/Guardian’s Signature __________________________________ Date __/__/____

Revised: July 26, 2012
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 ____ / ____ / ____

Revised: July 26, 2012
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

PA Department of Health: Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form. 7/2012 Revised: July 26, 2012
### SECTION 5: HEALTH HISTORY

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a doctor ever denied or restricted your participation in sport(s) for any reason?</td>
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<tr>
<td>Do you have an ongoing medical condition (like asthma or diabetes)?</td>
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<tr>
<td>Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?</td>
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<tr>
<td>Do you have allergies to medicines, pollens, foods, or stinging insects?</td>
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<td></td>
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<tr>
<td>Have you ever passed out or nearly passed out during exercise?</td>
<td></td>
<td></td>
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<tr>
<td>Have you ever passed out or nearly passed out after exercise?</td>
<td></td>
<td></td>
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<tr>
<td>Have you ever had discomfort, pain, or pressure in your chest during exercise?</td>
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<tr>
<td>Does your heart race or skip beats during exercise?</td>
<td></td>
<td></td>
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<tr>
<td>Has a doctor ever told you that you have high blood pressure?</td>
<td></td>
<td></td>
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<tr>
<td>Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)</td>
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<tr>
<td>Has anyone in your family died for no apparent reason?</td>
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<tr>
<td>Does anyone in your family have a heart problem?</td>
<td></td>
<td></td>
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<tr>
<td>Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does anyone in your family have Marfan syndrome?</td>
<td></td>
<td></td>
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<tr>
<td>Have you ever spent the night in a hospital?</td>
<td></td>
<td></td>
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<tr>
<td>Have you ever had surgery?</td>
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<td></td>
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</tbody>
</table>

| 17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendinitis, which caused you to miss a Practice or Contest? | Yes | No |
| If yes, circle affected area below:                                      |     |    |
| 18. Have you had any broken or fractured bones or dislocated joints?     | Yes | No |
| 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? | Yes | No |
| If yes, circle below:                                                    |     |    |
| 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? | Yes | No |
| 22. Do you regularly use a brace or assistive device?                   |     |    |

| 23. Has a doctor ever told you that you have asthma or allergies?        | Yes | No |
| 24. Do you cough, wheeze or have difficulty breathing during or after exercise? | Yes | No |
| 25. Is there anyone in your family who has asthma?                       | Yes | No |
| 26. Have you ever used an inhaler or taken asthma medicine?             |     |    |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | Yes | No |
| 28. Have you had infectious mononucleosis (mono) within the last month? | Yes | No |
| 29. Do you have any rash, pressure sore, or other skin problems?         | Yes | No |
| 30. Have you ever had a herpes skin infection?                           |     |    |

| CONCUSSION OR TRAUMATIC BRAIN INJURY                                    | Yes | No |
| 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? | Yes | No |
| 33. Do you experience dizziness 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? | Yes | No |
| 36. Have you ever been unable to move your arms or legs after being hit or falling? | Yes | No |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill? | Yes | No |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | Yes | No |
| 39. Have you had any problems with your eyes or vision?                 | Yes | No |
| 40. Do you wear glasses or contact lenses?                              |     |    |
| 41. Do you wear protective eyewear, such as goggles or a face shield?   | Yes | No |
| 42. Are you unhappy with your weight?                                   | Yes | No |
| 43. Are you trying to gain or lose weight?                              |     |    |
| 44. Has anyone recommended you change your weight or eating habits?     | Yes | No |
| 45. Do you limit or carefully control what you eat?                     | Yes | No |
| 46. Do you have any concerns that you would like to discuss with a doctor? | Yes | No |
| 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?                                                   | Yes | No |

**Explanation of "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/Guardian's Signature ____________________________ Date __/__/____

Revised: July 26, 2012
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.

Vision: R 20/____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal ______ Unequal ______

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

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 # ___________________________
AME’s Address __________________________________ Phone (_________)
AME’s Signature ________________________ MD, DO, PAC, CRNP, or SNP (circle one) Authorized Date of CIPPE _____/_____/____

Revised: March 22, 2013
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.

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?

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<th>Explain “Yes” answers here:</th>
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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 ______ / ______ / ______

Revised: July 26, 2012
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 ______

Revised: July 26, 2012
INSTRUCTIONS
Pursuant to the Weight Control Program adopted by PIAA, prior to the participation by any student in interscholastic wrestling, the Minimum Wrestling Weight (MWW) at which the student may wrestle during the season must be (1) certified to by an Authorized Medical Examiner (AME) and (2) established NO EARLIER THAN six weeks prior to the first Regular Season Contest day of the wrestling season and NO LATER THAN the Monday preceding the first Regular Season Contest day of the wrestling season (See NOTE 1). This certification shall be provided to and maintained by the student’s Principal, or the Principal’s designee.

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

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

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

Student’s Name __________________________ Age________ Grade______
Enrolled in __________________________ School

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

Urine Specific Gravity/Body Weight __________/________ Percentage of Body Fat _________ MWW __________

Assessor’s Name (print/type)________________________ Assessor’s I.D. #________________

Assessor’s Signature________________________ Date_____/_____/____

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

AME’s Name (print/type) __________________________ License #________________

Address________________________ Phone (_____)________________

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

For an appeal of the Initial Assessment, see NOTE 2.

NOTES:
1. For senior high school wrestlers coming out for the Team AFTER the Monday preceding the first Regular Season Contest day of the wrestling season the OPC will remain open until January 15th and for junior high/middle school wrestlers coming out for the Team AFTER the Monday preceding the first Regular Season Contest day of the wrestling season the OPC will remain open all season.
2. Any athlete who disagrees with the Initial Assessment may appeal the assessment results one time by having a second assessment, which shall be performed prior to the athlete’s first Regular Season wrestling Contest and shall be consistent with the athlete’s weight loss (descent) plan. Pursuant to the foregoing, results obtained at the second assessment shall supersede the Initial Assessment; therefore, no further appeal by any party shall be permitted. The second assessment shall utilize either Air Displacement Plethysmography (Bod Pod) or Hydrostatic Weighing testing to determine body fat percentage. The urine specific gravity testing shall be conducted and the athlete must obtain a result of less than or equal to 1.025 in order for the second assessment to proceed. All costs incurred in the second assessment shall be the responsibility of those appealing the Initial Assessment.

Revised: July 26, 2012
Dear Parent/Guardian:

Pittsburgh Public School District, in conjunction with UPMC Sports Medicine, is providing ImPACT baseline neurocognitive tests to designated student-athletes participating in certain interscholastic sports as agreed by the School District and UPMC in their Athletic Training Services Agreement. Designated student-athletes Pittsburgh Public School District will participate in ImPACT baseline neurocognitive testing to assess key functions affected by a concussion.

The ImPACT baseline neurocognitive test is used to establish a benchmark score when an athlete is in his or her non-concussed or “normal” state. The result of the ImPACT baseline neurocognitive test is used as a comparison tool to determine if your son or daughter can safely return to play following a subsequently incurred concussion.

A concussion potentially can affect the student-athlete’s school learning and social activities. Coordinated treatment between the UPMC certified athletic trainer, medical personnel, and the school district is important to assist in the student-athlete’s recovery.

If for any reason, you think your son or daughter may have had a hit to the head or any other potential for a concussion prior to taking the ImPACT baseline neurocognitive screening test, it is strongly recommended that he or she promptly seek medical care from UPMC Sports Medicine concussion experts or other healthcare professionals qualified in concussion diagnosis and treatment.

It should be noted that this ImPACT baseline neurocognitive test does not evaluate the subject for a concussion; identify past concussion(s); prevent future concussions or determine if your son or daughter is predisposed to a concussion.

Dear Parent/Guardian:

As part of a contractual agreement between UPMC Sports Medicine and Pittsburgh Public Schools, UPMC provides certified athletic trainers to aide in the prevention, recognition, evaluation, and treatment of athletic injuries.

To treat your son or daughter, two forms must be signed by parents/guardians of the student-athlete. One is the "Consent for Treatment, Payment and Health Care Operations." This gives the athletic trainer(s) and other associated healthcare personnel permission to assist or participate in providing care in the event of an injury or illness. The other form is the "Authorization for Release of Protected Health Information." This form allows the athletic trainer(s) to communicate with medical personnel and the school district's athletic department personnel in order to provide consultation, treatment and establish a plan of care for the injured or ill patient.

Please note that these forms have no relationship to your health insurance plan and in no way influence your choice of medical care. UPMC, as the employers of the certified athletic trainer(s) at Pittsburgh Public Schools, must have these forms completed in order to provide care for your son or daughter to comply with privacy and standard consent to treat laws.

In addition, copies of the UPMC Notice of Privacy Practices documents are available at the school, can be sent in the mail upon request, or viewed at http://www.upmc.com/HospitalsFacilities/hipaa/Pages/privacy-notice.aspx.

Please sign the attached documents. If you revoke this authorization or consent form, please contact the athletic office at 412-622-3944. We look forward to your student-athlete's safe participation in Pittsburgh Public Schools athletics. Thank you for your time.

Sincerely,

UPMC Sports Medicine
UPMC/UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)
CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I ___________________________ (print or type name) consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic injuries. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team physician, school nurse, and licensed physical therapists. Under the direction of a certified athletic trainer, college/university athletic training students and high school student aides may also provide care.

I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

I understand that copies of the UPMC Notice of Privacy Practices document are available at the school, can be sent in the mail upon my request or viewed at http://www.upmc.com/HospitalsFacilities/hipaa/Pages/privacy-notice.aspx. I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy Practices. ___________________________ Patient Initials

Patient signature
Date

Signature/identify on behalf of patient/relationship
Date

Signature/identify on behalf of patient/relationship
Date

For Office Use Only:

Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices:
________________________________

Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices:
________________________________

Rev 4/12
UPMC Sports Medicine

UPMC/UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)
Authorization for Release of Protected Health Information

RELEASE OF PROTECTED HEALTH INFORMATION

- I authorize UPMC to provide information related to my care to family/school/team physicians, school nurses, coaches, athletic directors, school principals, EMS personnel, and such other persons as is necessary needed for them to provide consultation, treatment, establish a plan of care or determine whether the Athlete may resume participation in school or sports activities.

- I authorize UPMC to use my billing information for UPMC internal departmental reporting purposes.

- I authorize UPMC (including its hospitals, other entities and programs) to use medical or other information maintained on electronic information systems or stored in various forms in connection with my care, health care operations, or payment for treatment and services.

- I understand that the health record(s) released by UPMC may be re-disclosed by the facility/person that receives the record(s) and therefore (1) UPMC and its staff/employees has no responsibility or liability as a result of the re-disclosure and (2) such information may no longer be protected by federal or state privacy laws.

- I understand that this Authorization is in effect for a period of one year from the date signed by the Athlete.

- I understand that this Authorization is in effect if I am treated for an injury during off-season workouts; however, no time frame specified shall go beyond one year from the date of signature.

- I understand that I have the right to revoke this Authorization form at any time by sending a written request to UPMC at the location where the Authorization was provided.

- I understand that my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.

- I understand that I am entitled to a copy of this completed Authorization form.

AGREED

Athlete/Patient Signature       Date

Parent/Guardian Signature (If Athlete is a Minor)       Date

Relationship

Rev 4/12