

METHACTON HIGH SCHOOL

PIAA PHYSICAL FORMS EXPLANATION AND COLLECTION PROCESS FOR THE 2015-2016 SCHOOL YEAR

All physicals for sports participation must be completed on the approved PIAA physical forms. NO EXCEPTIONS. These forms can be found online at www.methactonwarriors.org ([Click Here](#)) or in the Athletics' Office. Only original paperwork will be accepted. It is strongly encouraged you make a copy for your records.

***Complete Sport Eligibility Packet – Pages 1 to 3.**

***Complete PIAA Comprehensive Initial Pre-Participation Physical Evaluation**

Below is an explanation of the Comprehensive Interscholastic Pre-Participation Physical Exam (CIPPE).

The physical form consists of the following sections:

Sections 1-6: must be completed for the FIRST sport an athlete participates in for each new school year.

- Sections 1-5: Must be FULLY completed by the athlete and their parent/guardian.
- Section 6: Is the physical form to be completed by a physician on or after June 1st of each school year. If their physical is completed prior to this date the physician must still authorize they are able to participate in athletics after June 1st.

Section 7: Must be FULLY completed by the athlete and parent for the SECOND or THIRD sport an athlete would like to participate in.

Section 8: If you answer "yes" to any of the questions in Section 7, you must have Section 8 signed by the physician who performed your original physical.

PHYSICALS ARE DUE PRIOR TO THE START OF THE SPORT'S SEASON.

Fall Season: Physicals are due no later than August 10, 2015

*****FOOTBALL PHYSICALS ARE DUE NO LATER THAN AUGUST 3, 2015*****

Fall Physicals must be dated AFTER June 1st, 2015. Original paperwork can be mailed directly to the Methacton High School or dropped off in the Athletics' office during normal summer building hours (Monday-Wednesday 7:00am to 5:00, Thursday 7:00am to 4:30pm, Friday-Closed). Please make a copy for your records and check to make sure the paperwork is completely filled out. You will be notified for incomplete paperwork. Paperwork will be left in Athletics' office to be picked up and corrected. Physicals can be mailed to:

Methacton High School
1005 Kriebel Mill Road
Eagleville, PA 19403
Attn: Zachery Olds, Athletics Dept

Winter Season: Physicals are due no later than November 9th, 2015.

Original forms should be turned in directly to the Athletic Trainer. Forms should be dated after October 5, 2015. Please make a copy for your records and check to make sure the paperwork is completely filled out. Incomplete forms will be handed directly back to the athlete for correction.

Spring Season: Physicals are due no later than February 29th, 2016.

Original forms should be turned in directly to the Athletic Trainer. Forms should be dated after January 25, 2016. Please make a copy for your records and check to make sure the paperwork is completely filled out. Incomplete forms will be handed directly back to the athlete for correction.

*****Please note your child cannot participate in practices or events until their completed physical packet is on file and approved by the Athletic Training Office. Any questions can be directed to the Athletic Trainer, Zachery Olds, at zolds@methacton.org*****

2015-2016
SPORT ELIGIBILITY PACKET

THIS PACKET MUST BE COMPLETED AND RETURNED TO YOUR COACH **BEFORE**
PARTICIPATION WILL BE PERMITTED

PLEASE PRINT ALL INFORMATION

SPORT _____

NAME _____ HR _____ GRADE _____

DATE OF BIRTH _____ AGE ON LAST BIRTHDAY _____

PLACE OF BIRTH _____
TOWN STATE

HOME PHONE # _____ PARENT'S WORK# _____

Circle the grades below in which you have participated in this sport on an interscholastic basis.
BE SURE TO INCLUDE THIS YEAR.

7 8 9 10 11 12

Did you repeat a grade? Yes _____ No _____

If yes, what grade(s)? ***(Circle Below)***

7 8 9 10 11 12

What school did you attend last year? _____

The above information is accurate and truthful to the best of my knowledge. I understand that deliberately giving false information will make me ineligible for all sports.

X _____
Signature of Student Athlete

**METHACTON ATHLETIC OFFICE
CODE OF CONDUCT**

Rights/Responsibilities and Expectations

1. Every athlete who represents Methacton School District on an athletic team is expected to conduct himself/herself in such a manner as to reflect credit upon both the individual and Methacton.
2. Every athlete must remember that they are a student first, and an athlete second. Participation in athletics is a privilege granted to the student, not a right guaranteed to them.
3. Being a member of an athletic team does not entitle a student to any special privileges in school. Rather, it may carry an increased expectation of good school citizenship in the face of peer pressure. Athletes are expected to set examples of appropriate behavior and cooperation.
4. Students afforded the privilege of athletic participation must assume that these responsibilities accompany them at all times.

Athletic Discipline

1. Possession and/or use of controlled substances, anabolic steroids, or alcoholic beverages by an athlete at any time in season will result in the athlete being placed on Athletic Probation for fifteen (15) days or removed from the team, whichever comes first. While on Athletic Probation, the athlete is expected to participate in every practice and team obligation, but he/she is barred from participating in or traveling to any contest(s) during the probationary period. The coach may reinstate the athlete to full team membership at the end of this probationary period if behavioral expectations are met to the coaches' satisfaction.

The preceding statement will apply at any time and will apply whether such use is on or off school grounds. Penalty may be more severe (longer suspension, dismissal from the team) at the discretion of the athlete's coach or school administration. Any player dismissed or suspended from a team for violation of this policy will be denied the privilege of participating on any other team during the season.

2. Students whose offense(s), including but not limited to possession and/or use of controlled substances, anabolic steroids, or alcoholic beverages, occur outside of their respective season must appear before the Athletic Review Board before he/she is eligible for reinstatement to the athletic program and may be subject to Athletic Probation from the outset of any further athletic participation.
3. The coach of each team may establish additional rules and procedures that he/she expects his/her team members to follow. The coach may also establish disciplinary action for a breach in these rules and procedures. The use of tobacco and any other substance harmful to the athlete's person or which will not permit the athlete to perform at his/her highest level of potential is prohibited.

Athletic Review Board

The following offenses will require that the student submit a written request of the Athletic Director for review by the Athletic Review Board before the student may participate in subsequent sports seasons, or continue in their present sport season:

1. Dismissal or suspension from an athletic team for any reason, including the use of controlled substance, anabolic steroids and/or alcoholic beverages
2. Suspension from school for (3) three or more days
3. Any action that causes a student to be retained in the Juvenile Probation System or to be convicted/cited/involved in any criminal/illegal activity

Sport

X _____
Signature of Student-Athlete

Date

X _____
Signature of Parent/Guardian

**Methacton High School and Arcola Intermediate School
Athletic Program
Student-Athlete Insurance Information**

Dear Parent or Guardian:

All candidates for athletic teams are required to provide evidence of parental willingness to absolve the school of responsibility for costs due to injuries resulting from practice or competition while a member of an athletic team. Under Pennsylvania law (Political Subdivision Tort Claims Act) the School District is, in most cases, exempt from liability for injuries to students.

Kindly read the statement below and then check the method of your choice for covering the cost of possible injuries that the school cannot assume.

Thank you.

_____	_____	_____	_____
Student's Name	Sport	Date	Grade
_____	_____	_____	
Address	Zip Code	Phone Number	

I realize that even with proper safety equipment (helmet, etc.) and supervision, my child still may be injured, even paralyzed, while participating in sports. If I have questions about the potential hazards, I will contact the Athletic Office. I agree that, in the event of injury a physician or dentist designated by Methacton School District may render emergency treatment to my child.

(CHECK THE APPROPRIATE LINE BELOW)

- I am now carrying hospitalization and/or medical surgical insurance.

- I am carrying an accident insurance policy other than student accident insurance.

- I am otherwise prepared to accept and pay any such potential expenses.

X _____
Signature of Parent/Guardian



**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 _____

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
Cross Country	
Field Hockey	
Football	
Golf	
Soccer	
Girls' Tennis	
Girls' Volleyball	
Water Polo	
Other	

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Competitive Spirit Squad	
Girls' Gymnastics	
Rifle	
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	
Girls' Lacrosse	
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
Boys' Volleyball	
Other	

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

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

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.

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	

SECTION 5: HEALTH HISTORY

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

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you ever had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that apply):			CONCUSSION OR TRAUMATIC BRAIN INJURY 31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? <input type="checkbox"/> Yes <input type="checkbox"/> No 32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No 33. Do you experience dizziness and/or headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur			34. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
Head Neck Shoulder Upper arm Elbow Forearm Hand/Fingers Chest			46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Upper back Lower back Hip Upper Thigh Knee Calf/shin Ankle Foot/Toes			FEMALES ONLY		
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	48. How old were you when you had your first menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	49. How many periods have you had in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
			50. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

#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		<input type="checkbox"/> Heart murmur <input type="checkbox"/> Femoral pulses to exclude aortic coarctation <input type="checkbox"/> 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) Authorized 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.

- | | |
|---|---|
| <p>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? Yes No</p> <p align="right"><input type="checkbox"/> <input type="checkbox"/></p> <p>2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? Yes No</p> <p align="right"><input type="checkbox"/> <input type="checkbox"/></p> <p>3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? Yes No</p> <p align="right"><input type="checkbox"/> <input type="checkbox"/></p> | <p>4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? Yes No</p> <p align="right"><input type="checkbox"/> <input type="checkbox"/></p> <p>5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills? Yes No</p> <p align="right"><input type="checkbox"/> <input type="checkbox"/></p> <p>6. Do you have any concerns that you would like to discuss with a physician? Yes No</p> <p align="right"><input type="checkbox"/> <input type="checkbox"/></p> |
|---|---|

#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____ 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.

FEE FOR STUDENTS PARTICIPATING IN ATHLETICS, FALL PLAY & SPRING MUSICAL, MARCHING OR JAZZ BAND, WINTER GUARD & PERCUSSION ONLY

Please complete the following form and remit with student activity fee payment. Only one form per family is necessary, list the names of all students and submit this form along with payment (\$75 – ONE TIME FEE PER PARTICIPATING STUDENT). Payment may be made in person at the school to Mrs. Bennett in the athletic office, or mailed to the address below. Please send a self-addressed stamped envelope if you wish to have a receipt issued. Please feel free to review the frequently asked questions section at www.methacton.org/studentactivityfee or call 610-489-5054, with questions or concerns.

Make checks payable to Methacton School District. \$75 One-Time-Fee Per Participating Student

MAIL TO: ATTN. PAY TO PARTICIPATE / METHACTON HIGH SCHOOL / 1005 KRIEBEL MILL ROAD, EAGLEVILLE, PA 19403

Once paid, **NO ADDITIONAL FEE** is required; students pay only once, even if a student participates in more than one activity.

Students will be considered ineligible for their activity or sport if the fee is not paid within the designated two week grace period after the official start of the athletic season or activity.

Student(s) Last Name	Student(s) First Name	Student ID #	Sport/Activity

Parent's Name _____ Total Amount Enclosed: \$ _____

For Office Use Only	Check #	Date Paid	Employee's Initials