



BETHLEHEM

AREA SCHOOL DISTRICT

New Electronic Athletic Physical Information:

Starting for the 2024-25 school year, we will be offering electronic PIAA pre-participation athletic physical forms exclusively. **Physical must occur on/after May 1, 2024.******

What you as a parent need to know:

- 1-Follow the directions on the back of this page after going to the following website:
<https://studentcentral.bigteams.com/>
- 2-Once you create your parent account, you will link your student(s) accounts to yours
- 3-Complete the entire Emergency Contact page with your information
- 4-Click on Forms (left side), then on Athletic Forms
- 5-Complete all Sections 1-5, HIPAA, Consent to Treat and BASD Policy Letter form online as a parent with your signature and then have your student sign using their account (you're able to switch to your students account at the top of the page)
- 6-Print Section 5 and Section 6 (PIAA Physical Doctor Form)**
- 7-After Section 6 is completed by the doctor, take a picture and upload it to your account (trainers will keep the physical document on file in their office)

Physicals at Liberty HS: Monday, May 20, 5-8 p.m. in Liberty HS Aux Gym

Physicals at Freedom HS: Wednesday, May 29, 5-8 p.m. in Freedom HS Main Gym

Cost: Free

Make an appointment at Freedom HS using the following link:

<https://www.signupgenius.com/go/10C0E49ADAE28A0F5C07-49165624-basd>

***If your student played a fall sport/had a physical completed in the summer, follow these steps: (**NOT APPLICABLE FOR FALL SPORTS**)**

- 1-Follow the directions on the back of this page after going to the following website:
<https://studentcentral.bigteams.com/>
- 2-Once you create your parent account, you will link your student(s) accounts to yours
- 3-Complete the entire Emergency Contact page with your information
- 4-Click on the fall sport your played and any winter/spring sport you will be trying out for
- 5-Click on Forms (left side), then on Athletic Forms
- 6-Forms 1-6, HIPPA and Consent will be marked incomplete, click on Form 7 which is the re-certification form and fill in all areas.

7-Section 7: Re-Certification by Parent/Guardian (Winter)

If you have questions, please contact athletic trainer Brianna Fable (Brianna.Fable@sluhn.org) or athletic clerk Michael Blouse (mblouse@basdschools.org).



BigTeams Student Central Parents – Create Your Student Account Help Guide

1. Go to <https://studentcentral.bigteams.com/>
2. Click **Sign Up to Create New Account** and complete four step account creation
 - Who is this account for? **Select Parent/Guardian**
 - What School are you registering for? **Freedom High School, Bethlehem**
 - Input your Personal Information for your Parent/Guardian account
 - Input Username (Your Email) and Create Password
3. From the Linked Accounts page in **My Profile**, click "**+ Link Student Account**"
4. Search for your Student to see if they have already created an account.
 - NOTE: Check out the Self Help menu for "Account Linking Guide"
5. If your student does not have an account, click the hyperlink for "**If your student does NOT have an account OR is not yet 13 years old, click HERE**" and complete the five steps for creating the student account
6. Once created, be sure to input your **EMERGENCY CONTACT** information (Left Navigation under My Profile), and then complete the form requirements by clicking **FORMS** and then **ATHLETIC FORMS**
7. After signing the forms as a Parent, navigate back to My Profile followed by Linked Accounts, and have your student(s) use the **Sign In As** button to complete any "Awaiting Athlete Signature" requirements
 - NOTE: Check out the Self Help menu for "(Returning) Student/Parent "Sign In As" Feature" help guide
8. Once your forms are approved, a notification will be sent to your listed email address and/or mobile number. Notification settings can be adjusted by going to **My Profile** followed by **Notifications**

SECTION 5: HEALTH HISTORY

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

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Has a doctor ever denied or restricted your participation in sport(s) for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like asthma or diabetes)? | <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"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <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"/> |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply): | | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Heart infection | <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"/> |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem? | <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"/> |
| 14. Does anyone in your family have Marfan Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <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"/> |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | <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"/> |
- | | | | | | | | |
|------------|------------|----------|-----------|-------|-----------|------------------|---------------|
| Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand/ Fingers | Chest |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/ Toes |
20. Have you ever had a stress fracture?
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
22. Do you regularly use a brace or assistive device?

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 23. Has a doctor ever told you that you have asthma or allergies? | <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"/> |
| 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine? | <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"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you ever had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Do you experience dizziness and/or headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling? | <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"/> |
| 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"/> |
| 39. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses? | <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"/> |
| 42. Are you unhappy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
- MENSTRUAL QUESTIONS- IF APPLICABLE**
- | | | |
|--|--------------------------|--------------------------|
| 47. Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. How old were you when you had your first menstrual period? | | _____ |
| 49. How many periods have you had in the last 12 months? | | _____ |
| 50. When was your last menstrual period? | | _____ |

| | |
|----|-----------------------------|
| #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) Certification Date of CIPPE ____/____/____