

# Re-Certification of 2023-2024 Pre-Participation Forms

## DIRECTIONS

Dear Parent / Guardian / Student Athlete:

PIAA requires all student athletes to complete Section 1, 2, & 8: Re-Certification by Parent/Guardian in order for student athletes to compete in a subsequent second and/or third sport season during the year. If this is your first sport for the 2023-2024 school year, you have the wrong forms.

**Please follow the directions below for completing the attached Re-Certification packet.**

- Print forms** from the school website [www.BoilingSpringsAthletics.org](http://www.BoilingSpringsAthletics.org) under Athletic Forms. Click on Re-certification of Pre-Participation Forms. Click on the file. You will need to print, complete, and submit to the High School Office by the due dates.
- Complete Section 1, 2, and 8 of PIAA CIPPE form in full.
- If any Supplemental Health History questions are either checked **Yes or circled**, you **will** need to have Section 9 completed by your physician before turning in your form.
- If all Supplemental Health History questions are checked **No**, you **will not** need to complete Section 9.
- Submit this form to the school office by:
  - Friday November 10th for Winter sports
  - Last day in February for Spring sports.
  - If the office is closed on a due date, turn in forms on the next open day.
- Show up ready to practice on the first day of the season.

# 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 1<sup>st</sup>** and shall be effective, regardless of when performed during a school year, until the next May 31<sup>st</sup>.

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, of the student's school will then determine whether Section 8 need be completed.

## Section 1: Personal and Emergency Information

### PERSONAL INFORMATION

Student's Name \_\_\_\_\_ Check one: Male  Female

Date of Student's Birth: \_\_\_/\_\_\_/\_\_\_ Age of Student on Last Birthday: \_\_\_\_\_ Grade for Current School Year: \_\_\_\_\_

Year Enrolled in SMSD \_\_\_\_\_ Check all that apply: Traditional  Vo-Tech  Cyber  Homeschool  Other

Current Physical Address \_\_\_\_\_

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

List only the sport you intend to play and circle the grades you have competed in this sport only for SMSD including this year.

Fall \_\_\_\_\_ (7 8 9 10 11 12) Winter \_\_\_\_\_ (7 8 9 10 11 12) Spring \_\_\_\_\_ (7 8 9 10 11 12)

### EMERGENCY INFORMATION

Parent's/Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_ Emergency Phone # ( ) \_\_\_\_\_

Secondary Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Emergency Phone # ( ) \_\_\_\_\_

Family Physician \_\_\_\_\_ MD or DO (circle one)

Address \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Medical Insurance Carrier (**required**) \_\_\_\_\_ Policy # \_\_\_\_\_

Ins. Address \_\_\_\_\_ Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Student's Allergies \_\_\_\_\_

Student's Health Condition(s) of Which Emergency Personnel Should be Aware \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Student's Prescription Medications & Condition For \_\_\_\_\_

## Section 2: Certification of Parent/Guardian

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

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

	Sport	X Signature of Parent or Guardian below
FALL	Cheerleading/Comp Spirit - Grade 7-12	
	Cross Country - Grade 7-12	
	Field Hockey - Grade 7-12	
	Football - Grade 9-12	
	Golf - Grade 9-12	
	Soccer - Grade 9-12	
	Girls Volleyball Grade 9-12	
WINTER	Basketball – Grade 7-12	
	Bocce – Grade 9-12	
	Cheerleading - Grade 7-12	
	Swimming & Diving - Grade 9-12	
	Wrestling - Grade 7-12	
SPRING	Baseball – Grade 9-12	
	Soccer – Grade 7-8	
	Softball – Grade 9-12	
	Track & Field – Grade 7-12	
	Girls Volleyball – Grade 7-8	

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

Parent's/Guardian's Signature X \_\_\_\_\_ 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 X \_\_\_\_\_ 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 X \_\_\_\_\_ 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 X \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

Parent's/Guardian's Signature X \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SECTION 8: RE-CERTIFICATION BY PARENT/GUARDIAN**

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal, or the Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY.

If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the herein named student shall submit a completed Section 9, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

**SUPPLEMENTAL HEALTH HISTORY**

Student's Name \_\_\_\_\_ Male/Female (circle one)

Date of Student's Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age of Student on Last Birthday: \_\_\_\_ Grade for Current School Year: \_\_\_\_

Winter Sport(s): \_\_\_\_\_ Spring Sport(s): \_\_\_\_\_

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 9, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

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

- |   |                          |                          |  |                          |                          |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
|   | Yes                      | No                       |  | Yes                      | No                       |
| 1. Since completion of the CIPPE, have you sustained a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? | <input type="checkbox"/> | <input type="checkbox"/> | 3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below   |                          |                          | 4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?  | <input type="checkbox"/> | <input type="checkbox"/> | 5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 6. Do you have any concerns that you would like to discuss with a physician?   | <input type="checkbox"/> | <input type="checkbox"/> |

#s	Explain yes answers; include injury, type of treatment & the name of the medical professional seen by student

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

Student's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

**Section 9: Re-CERTIFICATION BY LICENSED PHYSICIAN OF MEDICINE OR OSTEOPATHIC MEDICINE**

This Form must be completed for any student who, subsequent to completion of Sections 1 through 6 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 9 may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to the Principal, or the Principal's designee, of the student's school, who, pursuant to ARTICLE X, LOCAL MANAGEMENT AND CONTROL, Section 2, Powers and Duties of Principal, subsection C, of the PIAA Constitution, shall "exclude any contestant who has suffered serious illness or injury until that contestant is pronounced physically fit by the school's licensed physician of medicine or osteopathic medicine, or if none is employed, by another licensed physician of medicine or osteopathic medicine."

**NOTE: The physician completing this Form must first review Sections 6 and 7 of the herein named student's previously completed CIPPE Form. Section 8 must also be reviewed if both (1) this Form is being used by the herein named student to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in a subsequent sport season in the same school year AND (2) the herein named student either checked yes or circled any Supplemental Health History questions in Section 8.**

**If the physician completing this Form is clearing the herein named student subsequent to that student sustaining a concussion or traumatic brain injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.**

Student's Name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Enrolled in \_\_\_\_\_ School \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Physician's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ MD or DO (circle one) Date \_\_\_\_\_

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

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Physician's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ MD or DO (circle one) Date \_\_\_\_\_