BUTLER
Varsity Track & Field
2022

Boys Head Coach
Coach Mike Seybert – 724-679-0687

Girls Head Coach
Coach John Williams – 724-272-3903

Important Dates

Registration Period
January 25 – March 4

1st Official Day of Track and Field Practice –
March 7, 2022 at the Annex
Girls Team – Upstairs Locker Room
Boys Team – Downstairs Locker Room

Practicing daily 3:10 to 5:30

Updates

FOLLOW BUTLER TRACK & FIELD ON TWITTER @ ButlerTandF
www.leaguelineup/Butlertornadotrackandfield

Butler Track & Field 2022

March

	Wed	23	**Exhibition** 3:45 at Butler High School
	Mon	28	– ***Pine Richland & Knoch** 3:45 at Butler High School

April

	Sat	2	- **Butler County Classic** 11:00 AM at Seneca Valley High School
	Wed	6	– ***Fox Chapel & *North Hills** 3:45 at Butler High School
	Sat	9	– **TSTCA Invitational** 9:30 AM at West Mifflin High School
	Tues	12	– ***North Allegheny** 3:30 at North Allegheny High School
	Tues	19	– ***Shaler** 3:45 at Butler High School
	Fri	22	– **Butler Invitational (Girl's)** 12:15 at Butler High School
	Sat	23	- **Butler Invitational (Boy's)** 12:15 at Butler High School
	Tue	26	– ***Seneca Valley** 4:00 at Seneca Valley High School
	Thu	28	– **9/10 Butler Invitational** 3:30 at Butler High School

May

	Tue	3	– **WPIAL Team Semi-Finals** 3:00 PM - TBA
	Fri	6	– **Baldwin Invitational** 12:00 at Baldwin High School
	Sat	7	– **Baldwin Invitational** 12:00 at Baldwin High School
	Tue	10	- **Last Chance Meet** TBD at TBD
	Wed	11	- **WPIAL Team Finals** 3:00 at West Mifflin High School
	Wed	18	– **WPIAL Individual Championships** TBD at Slippery Rock University
	Thu	26	– **PIAA Championships (Travel Day)**
	Fri	27	– **PIAA Championships**
	Sat	28	– **PIAA Championships** Shippensburg University

***Section Meet**

Registration

https://www.familyid.com/organizations/butler-area-school-district

WELCOME TO

GOLDEN TORNADO ATHLETICS!!

The Butler Area School District Athletic Department believes that a well-developed athletic program is integral in the educational progress of students and serves to enhance social, physical and educational development. The athletic program is an extension of the academic program and all athletes are urged to strive for excellence in both the classroom and in the athletic venues. Being a part of a team has many benefits and rewards. The central goal of this athletic program is for the student-athlete to learn the importance of integrity, respect, discipline, hard work, and how to deal with success and adversity. These teachings build good character and confidence, along with being the driving force for our student athletes to take this into their future life and become more productive members of the community. Participation in Butler Area School District Athletics however is a privilege and not a right; and that privilege is earned by each participant through his or her adherence to the rules and policies set forth by the Butler Area School District and the Pennsylvania Interscholastic Athletic Association.

CHANGES FOR THE 2021-2022 SCHOOL YEAR

The Butler High School Athletic Office has changed the registration process. These changes include:

- The full online registration will only need to be completed ONE TIME per school year for each student-athlete.
- Student-athletes who participate in subsequent sports in the same school year only need to complete the FamilyID program labeled "Recertification by Parent/Guardian" in the Winter and/or Spring.

REGISTRATION INSTRUCTIONS

INITIAL EVALUATION REGISTRATION

Prior to any student participating in practices, inter-school practices, scrimmages, and/or contests for any sport/team in the Butler Athletic Program, the legal parent(s)/guardian(s) of the student-athlete is required to complete the following:

1. **Register Online at Familyid.com** - Select the program below labeled 'Golden Tornado 2021-2022 Registration"

2. **Physical Forms** - The Health History form (now Section 6) is to be completed by the parent/guardian in its entirety and provided to the Authorized Medical Examiner (AME) performing the student-athlete's physical for review. The Physical Evaluation form (now Section 7) is to be completed and signed by the Authorized Medical Examiner (AME) performing the student-athlete's comprehensive initial pre-participation physical evaluation (CIPPE). Section 7 must be turned in to the Athletic Office prior to the deadlines shown below. **Please note that the physical (now Section 7) must be performed and dated **on or after June 1, 2021*** and is effective until the latter of the next May 31st or the conclusion of the spring sports season. *This form can be found on the right hand side of this screen under "Links".*

3. **Payment of Athletic Fee** - One-time payment per school year. The Butler Area School District will only accept cash or a check (made payable to BASD or Butler Area School District) at this time.

4. **ImPACT Test** - All student-athletes must have a valid ImPACT test on file with the Athletic Trainer's office prior to the first official practice or tryout. ImPACT Tests are valid for a period of two years. NO ATHLETE WILL BE PERMITTED TO TRYOUT OR PRACTICE UNLESS THIS IS COMPLETE. ImPACT Testing Dates are/will be located on the Butler Athletic Office website at www.butler-area.bigteams.com.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR

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 the following:

1. Register Online at Familyid.com - Select the program labeled **"Re-certification by Parent/Guardian"**. No form needs to be submitted.

Student's Name_____ Age_____ Grade_____

SECTION 6: HEALTH HISTORY

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

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

Head Neck Shoulder/arm Upper Elbow Forearm/Fingers Hand/ 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 ever had an x-ray for atlantoaxial (neck) instability?	☐	☐
22.	Do you regularly use a brace or assistive device?	☐	☐
23.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
24.	Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐
25.	Is there anyone in your family who has asthma?	☐	☐
26.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30.	Have you ever h ad a herpes skin infection?	☐	☐

CONCUSSION OR TRAUMATIC BRAIN INJURY

31.	Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
32.	Have you been hit in the head and been confused or lost your memory?	☐	☐
33.	Do you experience dizziness and/or headaches with exercise?	☐	☐
34.	Have you ever had a seizure?	☐	☐
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38.	Has a doctor told you that you or someone in our family has sickle cell trait or sickle cell disease?	☐	☐
39.	Have you had any problems with your eyes or vision?	☐	☐
40.	Do you wear glasses or contact lenses?	☐	☐
41.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42.	Are you unhappy with your weight?	☐	☐
43.	Are you trying to gain or lose weight?	☐	☐
44.	Has anyone recommended you change your weight or eating habits?	☐	☐
45.	Do you limit or carefully control what you eat?	☐	☐
46.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY

47.	Have you ever had a menstrual period?	☐	☐
48.	How old were you when you had your first menstrual period?	_____	
49.	How many periods have you had in the last 12 months?	_____	
50.	Are you pregnant?	☐	☐

#'s	Explain "Yes" answers here:

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

Student's Signature_____ Date_____/_____/_____

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

Parent's/Guardian's Signature_____ Date_____/_____/____

SECTION 7: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name_____ Age_____ Grade_____

Enrolled in_____School Sport(s)_____

Height_____ Weight_____ % Body Fat (optional)_____ Brachial Artery BP _____/_____ (_____/_____ , _____/_____) RP_____

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.
Age 10-12: BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/_____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal_____ Unequal_____

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

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

☐ **CLEARED** ☐ **CLEARED** with recommendation(s) for further evaluation or treatment for:_____

☐ **NOT CLEARED** for the following types of sports (please check those that apply):
☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS

Due to _____
Recommendation(s)/Referral(s) _____

AME's Name (print/type)_____ License #_____
Address_____ Phone ( )
AME's Signature_____MD, DO, PAC, CRNP, or SNP *(circle one)* Certification Date of CIPPE ____/_____/_____

SECTION 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):_____

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 # ( )_____

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
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?	☐	☐
An additional note to item #1. If serious illness or serious injury was marked "YES", please provide additional information below		
2. Since completion of the CIPPE, have you had a concussion (ie. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?	☐	☐
4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	☐	☐
5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills?	☐	☐
6. Do you have any concerns that you would like to discuss with a physician?	☐	☐

#'s	Explain yes answers; 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 7 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 7 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 no restrictions, except those, if any, set forth in Section 7 of that student's CIPPE Form.

1. _____

2. _____

3. _____

4. _____

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

Address_____ Phone ( )_____

Physician's Signature_____MD or DO *(circle one)* Date_____