

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

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	Wed	23	Exhibition 3:45 at Butler High School	
	Mon	28	- *Pine Richland & Knoch3:45 at Butler High School	
April				
	Sat	2	- Butler County Classic 11:00 AM at Seneca Valley High Scho	ool
	Wed	6	 - *Fox Chapel & *North Hills 3:45 at Butler High School 	
	Sat	9	TSTCA Invitational9:30 AM at West Mifflin High School	
	Tues	12	- *North Allegheny3:30 at North Allegheny High School	
	Tues	19	- *Shaler3:45 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 Valley4:00 at Seneca Valley High School	
	Thu	28	9/10 Butler Invitational3:30 at Butler High School	
May			· ·	
	Tue	3	WPIAL Team Semi-Finals3:00 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 Sat	27 28	PIAA ChampionshipsPIAA ChampionshipsShippensburg 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:

- 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 preparticipation 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".
- 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. <u>ImPACT Test</u> 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:

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

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cast, or crutches? If yes, circle below: Haad Neck Shoulder Upper Blow Forearm Upper Lower Hip Thigh Knee Caltishin Ankle Foot Toes Have you ever had a stress fracture? Have you been told that you have or have you ever had an x-ray for atlantoaxial (neck) instability? Do you regularly use a brace or assistive device? Have you pregnant? 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? Are you pregnant?		44.			required x-rays, MRI, CT, surgery, injections,	
Upper Lower Hip Thigh Knee Calbahn Ankle Foot Toes D. Have you ever had a stress fracture? Have you been told that you have or have you ever had an x-ray for atlantoaxial (neck) instability? Do you regularly use a brace or assistive device? Do you regularly use a brace or assistive device? 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? Are you pregnant?		45.	Chest	Handi	cast, or crutches? If yes, circle below:	Her
Dack back back back back back back back b	46. Do you have any concerns that you	46.	Foot		Upper Lower Hip Thigh Knee Calfishin	Upp
1. Have you been told that you have or have you ever had an x-ray for atlantoaxial (neck)	FEMALES ONLY		Toes		back back	
instability? Do you regularly use a brace or assistive device? Instability? How many periods have you had in the last 12 months? Are you pregnant?					Have you been told that you have or have	1.
device? last 12 months? 50. Are you pregnant?		49.	00/0	192001	instability?	2
	last 12 months?	50			, , , , , , , , , , , , , , , , , , , ,	
#'s Explain "Yes" answers here:	So. Me you pregnant:	50.				
	es" answers here:	ain "Yes" a	Exp		#'s	
hereby certify that to the best of my knowledge all of the information herein is true and complete.	n is true and complete.	n herein is t	informatio	all of the	ereby certify that to the best of my knowledge	here
Student's Signature Date /	Date / /				dent's Signature	tuder

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

Student's Name_			Age	Gra	de
Enrolled in					
HeightWeight					
of either the brachial artery blood primary care physician is recornage 10-12: BP: >126/82, RP: Vision: R 20/ L 20/	od pressure (BP) or re mmended. >104; Age 13-15: BP	esting pulse (RP) is above	the following levels, furth	er evaluation by the	ne student's
MEDICAL	NORMAL	,	ABNORMAL FINDINGS		
Appearance					
Eyes/Ears/Nose/Throat					
Hearing					
Lymph Nodes					
Cardiovascular		Heart murmur		coarctation	
Cardiopulmonary	13.	nyoloar originata or manar	- Syndrome		
Lungs					
Abdomen					
Genitourinary (males only)	1				
Neurological					
Skin					
MUSCULOSKELETAL	NORMAL		ABNORMAL FINDINGS	3	
Neck					
Back					
Shoulder/Arm					
Elbow/Forearm					
Wrist/Hand/Fingers					
Hip/Thigh					
Knee					
Leg/Ankle					
Foot/Toes					
hereby certify that I have rev herein named student, and, on student is physically fit to parti he student's parent/guardian i	the basis of such eva icipate in Practices, Ir in Section 2 of the PIA RED with recommend	aluation and the student's learner-School Practices, Scr AA Comprehensive Initial Falation(s) for further evaluation (s) for further evaluation (s) please check those that	HEALTH HISTORY, certify th immages, and/or Contest Pre-Participation Physical ion or treatment for:	at, except as spects in the sport(s) of Evaluation form:	ified below, the onsented to b
Collision Contact	T Non-Cont				
Due to	erral(s)				
Due to	erral(s)			License #_	

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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				86	Male/Femal	e (circle	one)
Date of Student's Birth: / /					for Current Sch	nool Year:	
Vinter Sport(s): Spring Sport(s):			port(s):	as the content of the styrift apart of the training of the section of the section of			
CHANGES TO PERSONAL INFORMATION (In the original Section 1: Personal and Emerge			w, identif	y any changes to the Pers	onal Informati	on set fo	rth in
Current Home Address							
Current Home Telephone # ()		Parer	nt/Guardia	an Current Cellular Phone #	()		
CHANGES TO EMERGENCY INFORMATION in the original Section 1: Personal and Emerc				tify any changes to the Er	nergency Infor	mation s	et forth
Parent's/Guardian's Name				R	elationship		
Address				Emergency Contact T	elephone # ()	
Secondary Emergency Contact Person's Name				R	elationship		
Address	50			Emergency Contact T	elephone #()	
Medical Insurance Carrier							
Address					elephone #(
Family Physician's Name					, MD or DO (circle one	9)
Address					hone # (
If any SUPPLEMENTAL HEALTH HISTORY ques completed Section 9, Re-Certification by Licensed the student's school. Explain "Yes" answers at the bottom of this form. Circle questions you don't know the answers to.	i Physicia						
Since completion of the CIPPE, have you sustained a serious illness and/or serious injury that required medical treatment from a licensed	Yes	No	4.	Since completion of the CIP experienced dizzy spells, black unconsciousness? Since completion of the CIP	outs, and/or PE, have you		
physician of medicine or osteopathic medicine? An additional note to item #1. If serious illness or seri marked "YES", please provide additional information to the serious informatio		was		experienced any episodes of u shortness of breath, wheezing, pain?	and/or chest		
2. Since completion of the CIPPE, have you	920			Since completion of the CIPPE any NEW prescription medicine			
had a concussion (ie. bell rung, ding, head rush) or traumatic brain injury?				Do you have any concerns that to discuss with a physician?	t you would like		
#'s Explain yes answers; include	e injury, ty	pe of treat	tment & th	e name of the medical profe	ssional seen by	student	
			2000/1-20				
I hereby certify that to the best of my knowle	dge all d	of the info	rmation	herein is true and comple	te.		
Student's Signature					Date		
I hereby certify that to the best of my knowle	edge all o	of the info	rmation	herein is true and comple	te.		
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:	AgeGrade
Enrolled in	School
Condition(s) Treated Since Completion of the Herein Na	med Student's CIPPE Form:
set forth below, I hereby authorize the above-identified s	I/or injury, which requires medical treatment, subsequent to the date student to participate for the remainder of the current school year in except those, if any, set forth in Section 7 of that student's CIPPE
Physician's Name (print/type)	License #
Address	Phone ()
Physician's Signature	MD or DO (circle one) Date
set forth below, I hereby authorize the above-identified additional interscholastic athletics with no restrictions, of Form.	for injury, which requires medical treatment, subsequent to the date student to participate for the remainder of the current school year in except those, if any, set forth in Section 7 of that student's CIPPE
1	
2	
Physician's Name (print/type)	
AddressPhysician's Signature	MD or DO (circle one) Date