

Kutztown Athletic Department

EMERGENCY PROCEDURE FORM

Student's Name: _____ Grade: _____
Address: _____
Home Number: _____ Cell Phone Number: _____
Parent's E-mail Address: _____

In case of emergency, illness or accident to the child named above the school is authorized to proceed as indicated below: (**Number each contact 1, 2, 3, etc. in order of desired action**)

- () Contact Mother (name & number) at: _____
- () Contact Father (name & number) at: _____
- () Contact Family Physician (name & number): _____
- () Take child to emergency hospital (name): _____
- () Take child to any licensed physician

Person who might be contacted if neither parent can be reached (name & number): _____

Family Dentist (name & number): _____

List any allergies or medical conditions that should be noted: _____

In the event that I cannot be reached in an emergency I hereby give my permission to the attending physician to hospitalize, secure proper treatment for and to order injections, anesthesia or surgery for my child:

Signature of Parent/Guardian: _____

Date: _____

Kutztown Area School District
Code of Conduct for Extra-Curricular Activities

1. Good sportsmanship and behavior are expected from all students and athletes. You represent Kutztown. Our activities and sports receive more publicity than other groups. We expect all students to uphold the reputation of Kutztown Area School District.
2. All school rules and regulations, including the Student Code of Conduct (see Student Handbook), are in effect during each practice, activity, or competition.
3. Many problems occur as a direct result of a failure to communicate. If you have a question or problem, please discuss it with a member of the coaching staff and/or advisor. Should the problem continue, please see the Athletic Director. **Issues not appropriate for parents** to discuss with coaches and /or advisors are: participation time, activity/team strategy, and/or other students.
4. All members of the team will ride the provided transportation to and from **away competitions**. Exceptions may be made with written parental permission using the Athletic Transportation Form and the approval of the coach and/or the Athletic Director. **Students may only travel to and from away competitions with a parent or guardian.**
5. Student athletes are responsible for the cleaning and upkeep of the equipment and uniforms issued to them. Clean uniforms must be turned in on the assigned collection date for each sport. Failure to turn in the proper clean uniform on the assigned collection date, damaged uniforms and/or equipment, and unaccounted uniforms and equipment either lost or stolen will be the monetary responsibility of each student athlete. A student athlete may not participate in a sport following the season where the student athlete has outstanding responsibilities, until these responsibilities are met.
6. All valuables must be left in a secured locker or given to the coach. The school is not responsible for lost or stolen articles.
7. Each coach/activity advisor has the prerogative to establish additional rules pertaining to the activity supervised. These rules may be no less stringent than the school district's policies and must be approved by the administration.
8. Any violation of this Code of Conduct or the Student Code of Conduct (see Student Handbook) may result in disciplinary consequences concerning involvement in extra-curricular activities, in addition to any consequences imposed under the Student Code of Conduct.
9. Students who are appointed to or elected to positions of leadership within the activities may be removed from the position if they are found to be in violation of the Student Code of Conduct.
10. Foul or objectionable language and/or behavior will not be tolerated. Incidents of this nature will be dealt with by the coaching staff/advisor and will be reported to the Athletic Director/Administration.
11. If a student is dismissed from a team, activity or function for discipline reasons, he/she may not join another sport or activity that same season.
12. If a student is involved in a school suspension, he/she will lose his/her **privilege** to participate in the sport or activity (including practice) for the duration of the suspension.
13. Any student ejected from an event/contest will be suspended from participation in the next event/contest. This rule is in effect for all competitions and activities. Further suspension may be warranted following the results of an investigation.
14. **Parents will be notified should consequences of the Code of Conduct be imposed.**

We have read the above and agree to abide by this Code of Conduct.

Signature of Parent/Guardian

Signature of Student

Date

Parental Consent for Medical Treatment

Participation in competitive sports may result in severe injury, including paralysis or even death. Improvements in sports equipment, physical conditioning, rule changes, and medical treatment have reduced their risks significantly. However, to eliminate such occurrences from athletics is merely impossible. Therefore, we would like to have your authorization to provide medical treatment and /or transport your child for further evaluation and medical care if deemed necessary. If you would like to give consent, please sign the form below. If you would not like to give consent, please give the reason why on the back of this form.

I hereby attest that all information is true and correct to the best of my knowledge. I also grant permission for the designee of the Kutztown Area School District (Certified Athletic Trainer, Coach, or Athletic Director) to give consent for medical treatment for my child if I am unavailable to give such consent.

Parent/Guardian Signature:_____Date:_____

Eligibility Requirements

Kutztown Area High School is a member of the Pennsylvania Interscholastic Athletic association (PIAA) and the Berks County Interscholastic Athletic Association (BCIAA) and abides by the adopted rules of each.

The eligibility requirements for athletics and extracurricular events are as follows:

- All students participating in the interscholastic athletic program must have passed a physical examination administered by an M.D. or D.O. during the academic year of participation. The signature of the parent/guardian must appear on the permission form prior to the completion of the physical. The physical examination is valid after June 1 for the academic year in which it was completed.
- The school will provide physical examinations for \$10.00 at the school, as announced. If a student does not take the opportunity to have the exam completed at the school, she/he will be required to complete a physical exam at her/his own expense prior to participation in sports that year.
- All Students must have a code of conduct form completed and signed by a parent/guardian before they may participate in any extracurricular activity. This form will be collected with the physical and turned into the High School Office or Athletic Director's Office.
- If a student is involved in a school suspension, she/he will lose her/his right to participate (including practice) for the duration of the suspension. The suspension ends with the return to school following the last day of the suspension.
- A student cannot be failing more than one course on a **weekly basis** in order to maintain eligibility. If the student athlete is ineligible, he/she can practice with the team but cannot compete in a PIAA contest. Eligibility will resume on the Monday following the week of ineligibility.
- A student who is failing more than one course at the end of any marking period will be ineligible to compete in a PIAA contest for 15 school days once the athletic department has been notified of the grades. The student athlete may still practice with their team.
- A principal may declare a student ineligible to participate in an extracurricular activity because of poor attendance, conduct, and discipline or academic performance. **Three discipline referrals will result in the loss of extracurricular activity participation for a period of two weeks.**
- Each student must be in attendance at school prior to 10:06 A.M. in order to practice in that day's extracurricular activities.
- Participation in interscholastic sports is not an excuse to miss any class, including fitness/physical education. All athletes shall be required to dress and participate in all physical education classes.
- All students shall be transported to an off-school-site event via school district transportation, unless otherwise approved by the principal or athletic director. Students requesting to return from off-campus activity with a parent must have a signed note from a parent/guardian and approved by the head coach and/or Athletic Director. **Students may return only with a parent and/or guardian.**

Signature of Parent/Guardian

Signature of Student

Date

Parent Email _____ Student Email _____

**KUTZTOWN ATHLETIC DEPARTMENT
CONSENTS AND VERIFICATIONS**

Name _____ Sport _____ Grade _____

Date of Birth _____ Age _____ Place of birth _____

Circle the grades you have competed in this sport including this present season: 7 8 9 10
11 12

Number of Semesters of Attendance in School - including this present semester:

(For a grade you have already completed, you should put a 2 on the line, for your current grade, you should put a 1 on the line if you are competing in a fall or winter sport, or a 2 if you are competing in a spring sport.)

7 _____ 8 _____ 9 _____ 10 _____ 11 _____ 12 _____

PIAA By-Laws Article IV-Section 1.

A pupil shall be eligible for practice or participation in each sport only when there is on file with the principal, a certificate of consent which is signed by his/her parent or guardian. I (the parent/guardian) acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in interscholastic athletic contests involving PIAA member schools. Such requirements include, but are not necessarily limited to: age, amateur status, school attendance, health, transfer from one school to another, semesters of attendance, seasons of sports participation, and academic performance.

Parent's Certificate

I hereby consent to the release by Kutztown Area School District to PIAA of any portion of the school record file of the student necessary to enable PIAA to determine whether the above named pupil is eligible to participate in interscholastic athletics involving PIAA member schools, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent or guardian, residence address of pupil, academic work completed, grades received, and attendance data.

In Accordance with the PIAA By-Laws, Article IV, Section 1, I give my consent for the above named student, a pupil of Kutztown Area School District, to take part in the athletic contests during the school year 20 ____-20 ____ in the sport listed above as indicated by my signature.

Parent/Guardian Signature **X** _____ Date _____

Assumption of Risk

I understand there are dangers involved with sports participation and are aware that participating in athletics can result in severe injury or even death from a variety of circumstances, which include, but are not limited to, falls, collisions with other athletes or equipment, and/or weather conditions. I understand that athletic participation can be inherently dangerous and understand and assume the risks involved.

Student Athlete Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Athletic Department Policies

I have read, and will adhere to the Kutztown Athletic Department Policies and team rules set forth by the coaching staff.

Student Athlete Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Kutztown Athletic Department

Equipment Guidelines and Information

Every parent and student athlete at Kutztown Area High School and Middle School must adhere to and be aware of the following information concerning the school uniforms which they are receiving and are responsible for throughout their season. This form is signed by the athlete and his/her parent or guardian, it must be returned to the athletic office prior to being issued a uniform.

1. The uniforms are the property of the Kutztown Area School District. DO NOT ALTER these uniforms in any way. i.e. cut neckbands or pads, tear elastic, fray, rip or discolor by washing.
2. Uniforms should be cleaned on a regular basis. Please follow all washing instruction on the uniform label. In the event there is no label please wash in cold water (to avoid shrinkage) and hang dry. Please avoid using the dryer whenever possible.
3. The uniform you are given is the uniform you are responsible for and are required to return. DO NOT exchange uniforms with teammates or loan to other students. Record your uniform numbers at home. Again, YOU MUST TURN IN THE EQUIPMENT ASSIGNED TO YOU.
4. Everyone must turn in their uniforms to the coach or athletic director within 72 hours after their season's last game. Uniform return dates will be set before the end of the season. Uniforms must be returned washed and cleaned and in the same general condition in which it was received.
 - a. Students will be charged the full REPLACEMENT cost of the uniform.
 - b. Students will not be issued a uniform for a subsequent sports season.
 - c. Students will not be allowed to use the fitness center
 - d. Students may be assigned detention and will not be permitted to take final exams.
5. Students are financially responsible for the replacement cost of lost, destroyed, stolen or damaged uniforms. This includes uniforms that are flawed by improper laundering or torn. Payment plans will be worked out if necessary.

Student Name – Printed

Student Signature

Parent Name – Printed

Parent Signature



**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 latter of the next May 31st or the conclusion of the spring sports season.

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 or Other Medical Personnel Should be Aware _____

Student's Prescription Medications and conditions of which they are being prescribed _____

Parent Email: _____ Student Email: _____

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. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student.

Parent's/Guardian's Signature _____ 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 _____ 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.

_____ Signature of Student-Athlete	_____ Print Student-Athlete's Name	Date ____/____/____
_____ Signature of Parent/Guardian	_____ Print Parent/Guardian's Name	Date ____/____/____

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"/> <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"/>		
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			34. Have you ever had a seizure?	<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"/>	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"/>
11. Has anyone in your family died for no apparent reason?	<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"/>
12. Does anyone in your family have a heart problem?	<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"/>
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"/>	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"/>
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<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"/>
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:			42. Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest			43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes			44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<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"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY		
			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?	<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) Certification 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.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 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? | <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"/> |
| 3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 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"/> |
| 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 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.

2017 - 2018 School Year Concussion Summary

A concussion is a type of traumatic brain injury that is caused by a blow to the head or body, a fall, or another injury that jars or shakes the brain inside the skull. Because of the chance of permanent brain damage, it is important to contact a doctor if you believe your child has sustained a head injury. Some symptoms of head injuries are the following:

- **Excessive drowsiness.** Your child may be sleepy and tired after a head injury. However, you should be able to wake your child as you would normally from a deep sleep.
- **Vomiting that does not stop.** Sometimes a child may vomit one or two times after a head injury. However, the vomiting should not continue or start again later. Do not give your child anything to eat for about 2 hours after a head injury. After 2 hours begin by giving your child sips of liquids such as water, Kool Aid, or popsicles. If there is no vomiting after these liquids, your child may try small amounts of regular food.
- **Unsteady balance or movement.** Watch your child sit, walk, and move. Be sure that your child moves equally on the right side and the left side of their body.
- **Headache that gets worse.** Many children complain of a headache after a head injury. The headache should not get worse. Do not give any medication without a doctor's permission as this may mask a serious medical problem.
- **Confusion, disorientation.** Your child doesn't know who or where s/he is or other change in behavior.
- **Seizures or convulsions.** If your child should have a seizure, do not panic. Place your child on one side so s/he cannot fall and can breathe freely. **Then call your child's doctor or go the emergency department immediately.**

The following information has been documented regarding Kutztown Middle/High School students suffering from concussions in the 2017-2018 school year.

High School Athletics/School/Home

- Soccer – 1
- Football - 2
- Wrestling – 1
- Twirling Team – 1
- Cheerleading – 2
- Basketball - 1
- Gym class - 1
- School (other than gym) - 2
- Home – 5
- Club Rugby – 2
- Car Accident - 2

Middle School Athletics/School/Home

- Soccer – 4
- Basketball – 2
- Gym – 4
- School (other than gym)– 3
- Home – 2
- Youth football – 2
- Youth soccer - 1

Total High School Concussions – 20

Total Middle School Concussions - 18

Please take time to familiarize yourself with the Concussion policy. It can be found on the district website as Policy 123.1.

In the event your child sustains a concussion, there is paperwork that must be completed by a physician for academic/activity accommodations. This paperwork may be printed from the Health Services link on the school website or obtained from the school nurse or athletic trainer. Each case will be reviewed and updated every 30 days.

Any questions or concerns regarding concussions and/or the policy, feel free to contact me at the High School 610-683-7346 ext. 5544.

Sincerely,

Brenda Loeb RN

Brenda Loeb RN, BSN, CSN, M.Ed. , Certified School Nurse