

PENN HILLS ATHLETICS
SPORT PHYSICAL PACKET 2020-21

The doctor's physical evaluation is only valid if after June 1, 2020

STUDENT NAME: _____ STUDENT ID #: _____

SPORT(S): _____

SCHOOL: _____ GRADE: _____ AGE: _____ BIRTH DATE: ____/____/____

PARENTS/GUARDIANS:

- **NEW FOR 2020-21:** Sections 1-6 of the PIAA pre-participation physical forms are available ONLINE through Planet HS. Please create a student and parent account at www.planeths.com and complete the required information on your phone, tablet, or computer. The attached doctor's form (Section 6) must be dated and signed by a doctor and uploaded to your Planet HS account.
- UPMC Sports Medicine provides athletic training services for our student-athletes as part of a contractual agreement with the Penn Hills School District. **Please sign the attached UPMC document.** Please note that the forms have no relationship to your health insurance plan and in no way, influence your choice of medical care.
- All student-athletes in their sports season are covered under the Penn Hills All-Sports Liability program as a secondary coverage only. All claims must be submitted to your insurance company first. If your child is injured and you have questions, please call the High School Athletic Office at 412-793-7000 x5206 or 5207.

The Penn Hills School District (PHSD) offers the following sports to PHSD students in grades 7-12. In addition, students who are enrolled in cyber school, charter school, or are home schooled are eligible to participate in PHSD athletics upon proving residency within the Penn Hills School District.

Penn Hills High School Sports (9th-12th Grade):

FALL: Cheerleading, Co-Ed Cross Country, Football, Golf, Boys Soccer, Girls Soccer, Girls Tennis and Girls Volleyball

WINTER: Boys Basketball, Girls Basketball, Co-Ed Bowling, Cheerleading, Co-Ed Indoor Track, Co-Ed Physical Fitness, Co-Ed Swimming & Diving, and Wrestling

SPRING: Baseball, Fast Pitch Softball, Co-Ed Track & Field, Boys Volleyball

Linton Middle School Sports (7th & 8th Grade): The Middle School sports seasons are staggered to encourage student-athletes to try out a variety of sports, even within the same "season."

FALL: Cheerleading, Football, Girls Soccer, Boys Soccer, Girls Basketball, Co-Ed Swimming

WINTER: Boys Basketball, Wrestling, Girls Volleyball

SPRING: Fast Pitch Softball, Co-Ed Track & Field

Print Athlete's Name_____
Print Athlete's Sport

As part of a contractual agreement with UPMC Sports Medicine, certified athletic trainers may aide in the prevention, recognition, evaluation, and treatment of athletic injuries. **Please note that the forms below have no relationship to your health insurance plan and in no way, influence your choice of medical care.** UPMC must have these forms completed to comply with privacy and standard consent to treat laws.

(1) UPMC Authorization for Release of Protected Health Information

- I authorize UPMC to provide information related to the athlete's care to family/school/team physicians, school nurses, coaches, athletic directors, school principals, EMS personnel, and such other persons as is necessary needed for them to provide consultation, treatment, establish a plan of care or determine whether the athlete may resume participation in school or sports activities.
- I authorize UPMC to use the athlete's medical information for UPMC internal departmental reporting purposes.
- I authorize UPMC (including its hospitals, other entities and programs) to use medical or other information maintained on electronic information systems or stored in various forms about the athlete's care, health care operations, or payment for treatment and services.
- I understand that the health record(s) released by UPMC may be re-disclosed by the facility/person that receives the record(s) and therefore (1) UPMC and its staff/employees has no responsibility or liability because of the re-disclosure and (2) such information may no longer be protected by federal or state privacy laws.
- I understand that this Authorization is in effect for a period of one year from the date signed by the athlete.
- I understand that this Authorization is in effect if the athlete is treated for an injury during off-season workouts; however, no time frame specified shall go beyond one year from the date of signature.
- I understand that I have the right to revoke this Authorization form at any time by sending a written request to UPMC at the location where the Authorization was provided.
- I understand that my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization. • I understand that I am entitled to a copy of this completed Authorization form.

Print Athlete's Name _____

Print Athlete's Sport _____

(2) UPMC Consent for Treatment and Healthcare Operations

I consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic injuries. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team physician, school nurse, and licensed physical therapists. Under the direction of a certified athletic trainer, college/university athletic training students and high school student aides may also provide care.

I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

In the event of ImPACT baseline testing, I understand the ImPACT baseline testing provided by UPMC Sports Medicine is not intended to prevent, diagnose, or treat a concussion and is not to be administered following a possible concussion. If the athlete suffers a concussion, the administration of an ImPACT post-test is generally conducted at the discretion of the concussion specialist at their facility.

(3) UPMC Privacy Practices

I understand that copies of the UPMC Notice of Privacy Practices document are available at the school, can be sent in the mail upon my request or viewed at <http://www.upmc.com/patients-visitors/privacy-info/Pages/default.aspx>. I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy Practices.

By signing below, I am acknowledging the above (1) Authorization for Release of Protected Health Information, (2) Consent for Treatment and Healthcare Operations, and (3) Notice of Privacy Practices.

Athlete signature

Date

Parent or guardian signature/relationship

Date

Parent or guardian signature/relationship

Date

For Office Use Only:

Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices: _____

Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices: _____

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		
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur			31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			32. Have you been hit in the head and been confused or lost your memory?	<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"/>	33. Do you experience dizziness and/or headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<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"/>
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"/>	36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan syndrome?	<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"/>
15. Have you ever spent the night in a hospital?	<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"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
			43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
			44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
			45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
Head Neck Shoulder Upper arm Elbow Forearm Hand/Fingers Chest			46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Upper back Lower back Hip Upper arm Thigh Knee Calf/shin Hand/Fingers Ankle Foot/Toes			FEMALES ONLY		
			47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	48. How old were you when you had your first menstrual period?	_____	_____
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"/>	49. How many periods have you had in the last 12 months?	_____	_____
22. Do you regularly use a brace or assistive device?	<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 ____/____/____