Special Olympics Pennsylvania

# PIAA Paperwork: Instructions for IUS participants

## Entire packet MUST be completed by athletes and partners

**SOPA Wavier for Participation (Pages 1-2)**

- Fill out completely
- Make sure School Name is filled in
- Check if Athlete or Unified Partner
- Signature at the bottom of page 1
- Signature on page 2
    - If your son or daughter is 18 or older, they may sign for themselves but need a witness

**PIAA Pre-participation Physical Evaluation**

*Gray highlights indicate places where parent/guardian and student signatures are REQUIRED*

**Section 1:**

- Complete entirely
- At least one Emergency Contact MUST be listed

**Section 2:**

- Fill out A.
    - In the "Other" box write IUS Bocce (winter) or IUS Track and Field (spring)
- Make sure sections B-F are signed with date

**Section 3:**

- Read and sign bottom of page
    - Make sure your son or daughter signs as well

**Section 4:**

- Read and sign bottom of page
    - Make sure your son or daughter signs as well

**Section 5:**

- Fill out entirely
- Make sure you and your son or daughter sign at the bottom of the page

**Section 6 and 6a:**

- Fill out first 2 lines: name, age, grade, school and sport(s)
- Remainder of the form needs to be completed by a doctor (MD/DO), a physician assistant (PAC), a certified nurse practitioner (CRNP), school nurse practitioner (SNP), Bachelors of Science in Nursing (BSN) or Associates of Science in Nursing (ASN)
    - With signatures at end of both Section 6 and Section 6a.

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**Section 7 & 8**: Are ONLY to be completed if your son/daughter HAS participated in a 2018 PIAA Fall Sport OR suffered an injury that requires a doctor's clearance to return to play (i.e. Concussion).

**Section 9:** You do NOT need to complete this section.

**School Year: 2018-19**

Special Olympics Pennsylvania

## Waiver for participation in Interscholastic Unified Sport (IUS)

In addition to the PIAA medical form, this waiver must be filled out completely in order for the athlete/partner to participate (practice or compete) in Interscholastic Unified Sports.

# School Name: _____ ☐ Athlete ☐ Unified Teammate/Partner

| | |
|---|---|
| Participant Name (PRINT): | Sport(s): |
| Participant's Email: | Phone#: |
| Address: | City, State, Zip: |
| Parent/Guardian Name (PRINT): | Relationship to participant: |
| Parent/Guardian Email: | Phone #: |
| Address: | City, State, Zip: |

**HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Down Syndrome | ☐ | ☐ | Fainting Spells |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Heat Illness or Cold Injury |
| ☐ | ☐ | Hear Problems | ☐ | ☐ | Hernia or Absence of 1 testicle |
| ☐ | ☐ | Seizures | ☐ | ☐ | Recent Contagious Disease or Hepatitis |
| ☐ | ☐ | Legally Blind | ☐ | ☐ | Kidney problems or loss of function in one kidney |
| ☐ | ☐ | Vision problems and/or less than 20/20 vision in one or both eyes | ☐ | ☐ | Pregnancy |
| ☐ | ☐ | Legally Deaf | ☐ | ☐ | Bone or Joint problems |
| ☐ | ☐ | Hearing Aid/Hearing problems | ☐ | ☐ | Contact Lens/Glasses |
| ☐ | ☐ | Requires Wheelchair | ☐ | ☐ | Dentures/False teeth |
| ☐ | ☐ | Motor impairment requiring special equipment | ☐ | ☐ | Emotional problems |
| ☐ | ☐ | Non-Verbal Individual | ☐ | ☐ | High/Low Blood pressure |
| ☐ | ☐ | Bleeding Problem | ☐ | ☐ | Asthma |
| ☐ | ☐ | None ☐ Atlanto-axial instability Evaluation by X-ray (check Yes if positive, No if negative and None for no X-ray available) | ☐ | ☐ | Special Diet Needs (if yes, explain): |
| ☐ | ☐ | Other (explain): | | | |

Signature of parent/caregiver/adult athlete: _____ date _____/_____/_____

**Complete release on opposite side.**

**Special Olympics Pennsylvania**
2570 Blvd. of the Generals, Suite 124, Norristown, PA, 19403 **Tel** + (610) 630-9450 **Toll Free** + (800) 235-9058 **Fax** + (610) 630- 9456
**www.specialolympicspa.org**

**RELEASE TO BE COMPLETED BY PARENT or GUARDIAN of <u>minor athlete (under 18 years of age or individual unable to consent)</u>**

I am the parent/guardian of _____, the minor athlete, on whose behalf I have submitted the attached application for participation in Special Olympics. I hereby represent that the athlete has my permission to participate in Special Olympics activities.
I further represent and warrant that to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics. With my approval, a licensed physician has reviewed the health information set forth in the athlete's application, and has certified based on an independent medical examination that there is no medical evidence, which would preclude the athlete's participation. I understand that if the athlete has Down Syndrome, he/she cannot participate in sports or events, which, by their nature, result in hyper-extension, radical flexion or direct pressure on the neck or upper spine, unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability." Available from the Special Olympics Chapter program in my state, or the athlete has had a full radiological examination, which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-axial Instability, the athlete must have the radiological examination before he/she can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.
In permitting the athlete to participate, I am specifically granting my permission, (both during and anytime after), to Special Olympics to use the athlete's likeness, name, voice and words in television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.
If a medical emergency should arise during the athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the athlete's health and well-being.
I am the parent (guardian) of the athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above.
I hereby give my permission for the athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

_____ _____

Signature of Parent/Guardian Date

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**RELEASE TO BE COMPLETED BY ADULT ATHLETE (must be 18 years of age and able to consent)**

I, _____ am at least 18 years old and have submitted the attached application for participation in Special Olympics.
I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Chapter program in my state, or I have had a full radiological examination which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.
Special Olympics has my permission, (both during and anytime after), to use my likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.
If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.
I, the athlete named above, have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

Signature of Adult Athlete:_____ Date: _____

*I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied based on that review that the athlete understands this release and has agreed to its terms.*

Name (Print) _____ Relationship to athlete (i.e. family member, teacher, coach, etc.): _____

# 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 _____

_____

## 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.

| _____ | _____ | Date____/____/_____ |
|---|---|---|
| Signature of Student-Athlete | Print Student-Athlete's Name | |

| _____ | _____ | Date____/____/_____ |
|---|---|---|
| Signature of Parent/Guardian | Print Parent/Guardian's Name | |

Student's Name _____ Age_____ Grade_____

## SECTION 5: HEALTH HISTORY

**Explain "Yes" answers at the bottom of this form.**
**Circle questions you don't know the answers 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, Upper arm, Elbow, Forearm, Hand/ Fingers, 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 had an x-ray for atlantoaxial (neck) instability? | ☐ | ☐ |
| 22. | Do you regularly use a brace or assistive device? | ☐ | ☐ |

| | | Yes | No |
|---|---|---|---|
| 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 your 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 had 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 your 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 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 | | ☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation<br>☐ 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, ASN, BSN or SNP *(circle one)* Certification Date of CIPPE ___/____/___

**SECTION 6a: Special Olympics Pennsylvania Additional Medical Exam Screening**
**REQUIRED FOR ALL PARTICIPANTS OF INTERSCHOLASTIC UNIFIED SPORTS**

For individuals participating in Special Olympics sports, we want to assure individuals are screened appropriately for Atlanto-axial instability or AAI.

| **Please indicate if you have had the following by answering yes or no:** | **Yes** | **No** |
|---|---|---|
| 1. Burner, stinger or pinched nerve in neck, arms, shoulders/hands | | |
| 2. Difficulty controlling bowels | | |
| 3. Difficulty controlling bladder | | |
| 4. Numbness in arms or hands | | |
| 5. Numbness in legs or feet | | |
| 6. Tingling in arms or hands | | |
| 7. Tingling in legs or feet | | |
| 8. Weakness in arms or hands | | |
| 9. Weakness in legs or feet | | |
| 10. Recent change in coordination | | |
| 11. Recent change in ability to walk | | |

I have reviewed the health information and examined the named in the application, and certify there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics:

AME's Signature_____ MD, DO, PAC, CRNP, ASH, BSN or SNP *(circle one)*

Authorized 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? | ☐ | ☐ |
| 2. Since completion of the CIPPE, have you had a concussion (i.e. 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 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____ wresting 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.