Athlete Checklist

Fleetwood Area School District

St Luke's Sports Medicine

Please be sure the following is completed prior to handing in your physical

- ☐ Section 1
  - completed in full
- ☐ Section 2
  - requires 6 parent signatures
- ☐ Section 3 + 4
  - each require a parent and a student signature
- ☐ Section 5 –
  - complete the questionnaire, any "yes" should be appropriately explained in the space provided
  - parent and student signature
- ☐ Section 6 – **completed and signed by a doctor after June 1st**
- ☐ Section 7 – Re-Certification for Winter/Spring Sports
  - parent and student signature
- ☐ Student Handbook
  - parent and student signature
- ☐ Consent to treat
  - Complete information
  - parent signature
- ☐ St Luke's HIPPA Authorization
  - Review and complete
- ☐ ImPACT Baseline Test Instruction Sheet
- ☐ ImPACT Baseline Test Acknowledgement of Completion Form
  - Complete information
  - parent and student signature
  - attach copy of ImPACT completion receipt

Once completed paperwork should be turned into the white box outside for the athletic director's office in the high school, or in the white box outside of the middle school main office.

INCOMPLETE PAPERWORK WILL RESULT IN BEING UNABLE TO PARTICIPATE
Once handed in paperwork requires 24 hours to process, athletes will not be cleared to participate until all files have been updated and coaches are given their emergency contact information.

Please reach out to the athletic trainers for any medical concerns.

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 # ( )_____

Parent/Guardian E-mail Address:_____

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 7 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) occurs when the heart suddenly and unexpectedly stops beating. 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 350,000 cardiac arrests that occur outside of hospitals each year. More than 10,000 individuals under the age of 25 die of SCA each year. SCA is the number one killer of student athletes and the leading cause of death on school campuses.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as

- Dizziness or lightheadedness when exercising;
- Fainting or passing out during or after exercising;
- Shortness of breath or difficulty breathing with exercise, that is not asthma related;
- Racing, skipped beats or fluttering heartbeat (palpitations)
- Fatigue (extreme or recent onset of tiredness)
- Weakness;
- Chest pains/pressure or tightness during or after exercise.

These symptoms can be unclear and confusing in athletes. Some may ignore the signs or think they are normal results off physical exhaustion. If the conditions that cause SCA are diagnosed and treated before a life-threatening event, sudden cardiac death can be prevented in many young athletes.

What are the risks of practicing or playing after experiencing these symptoms?

There are significant risks associated with continuing to practice or play after experiencing these symptoms. The symptoms might mean something is wrong and the athlete should be checked before returning to play. When the heart stops due to cardiac arrest, 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 experience a SCA die from it; survival rates are below 10%.

Act 73 – Peyton's Law - Electrocardiogram testing for student athletes

The Act is intended to help keep student-athletes safe while practicing or playing by providing education about SCA and by requiring notification to parents that you can request, at your expense, an electrocardiogram (EKG or ECG) as part of the physical examination to help uncover hidden heart issues that can lead to SCA.

Why do heart conditions that put youth at risk go undetected?

- Up to 90 percent of underlying heart issues are missed when using only the history and physical exam;
- Most heart conditions that can lead to SCA are not detectable by listening to the heart with a stethoscope during a routine physical; and
- Often, youth don't report or recognize symptoms of a potential heart condition.

What is an electrocardiogram (EKG or ECG)?

An ECG/EKG is a quick, painless and noninvasive test that measures and records a moment in time of the heart's electrical activity. Small electrode patches are attached to the skin of your chest, arms and legs by a technician. An ECG/EKG provides information about the structure, function, rate and rhythm of the heart.

Why add an ECG/EKG to the physical examination?

Adding an ECG/EKG to the history and physical exam can suggest further testing or help identify up to two-thirds of heart conditions that can lead to SCA. An ECG/EKG can be ordered by your physician for screening for cardiovascular disease or for a variety of symptoms such as chest pain, palpitations, dizziness, fainting, or family history of heart disease.

- ECG/EKG screenings should be considered every 1-2 years because young hearts grow and change.
- ECG/EKG screenings may increase sensitivity for detection of undiagnosed cardiac disease but may not prevent SCA.
- ECG/EKG screenings with abnormal findings should be evaluated by trained physicians.
- If the ECG/EKG screening has abnormal findings, additional testing may need to be done (with associated cost and risk) before a diagnosis can be made, and may prevent the student from participating in sports for a short period of time until the testing is completed and more specific recommendations can be made.
- The ECG/EKG can have false positive findings, suggesting an abnormality that does not really exist (false positive findings occur less when ECG/EKGs are read by a medical practitioner proficient in ECG/EKG interpretation of children, adolescents and young athletes).
- ECGs/EKGs result in fewer false positives than simply using the current history and physical exam.

The American College of Cardiology/American Heart Association guidelines do not recommend an ECG or EKG in asymptomatic patients but do support local programs in which ECG or EKG can be applied with high-quality resources.

Removal from play/return to play

Any student-athlete who has signs or symptoms of SCA must be removed from play (which includes all athletic activity). The symptoms can happen before, during, or after activity.

Before returning to play, the athlete must be evaluated and cleared. 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 this form and understand the symptoms and warning signs of SCA. I have also read the information about the electrocardiogram testing and how it may help to detect hidden heart issues.

_____	_____	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:	❑	❑
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?	❑	❑

Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest
Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes

		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?	❑	❑
	MENSTRUAL QUESTIONS- IF APPLICABLE	❑	❑
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.	When was your last menstrual period?		

#'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 ❑ 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 _____

Parent/Guardian E-mail Address:_____

Address _____ Emergency Contact Telephone # ( )_____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # ( )_____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Telephone # ( )_____

Family Physician's Name_____, MD or DO (circle one)

Address _____Telephone # ( )_____

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

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

	Yes	No
1. Since completion of the CIPPE, have you sustained a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine?	❑	❑
An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below		
2. Since completion of the CIPPE, have you had a concussion (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; include injury, type of treatment & the name of the medical professional seen by student

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

Student's Signature _____Date____/____/_____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.
Parent's/Guardian's Signature _____Date____/____/_____

Section 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 5 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.

Fleetwood Area School District
Student Athlete Handbook & Code of Responsibilities

I agree to fulfill the provisions of the Student Athletic Handbook and the Code of Responsibilities.

Name (please print):_____Grade:_____

Sport (s) participating in:_____

Student Signature:_____

I agree with the principles established and will cooperate with the coaches and school administration in seeing that my son/daughter follows these regulations.

Parent Signature:_____ Date:_____

The Fleetwood Student-Athlete Handbook can be found on the school's website under the athletics tab.

This form only needs to be filled out and signed one time per year for each athlete.

Questions/concerns regarding the Handbook and Code of Conduct should be directed to the athletic director.

PATIENT LABEL AREA

St Luke's
UNIVERSITY HEALTH NETWORK

SPORTS MEDICINE AND ORTHOPEDIC CARE CONSENT TO TREAT–YOUTH

CONSENT TO TREAT

I am the parent/legal guardian of the child named below. I permit St. Luke's University Health Network and its personnel to deliver health care and treatment to my child at _____ **(name of school district/program)** (the "Program") practice and games by appropriately qualified health care providers (athletic trainers, physical therapists, physicians, etc.). Such health care and treatment may include providing first aid and initial management of injuries, rehabilitation, musculoskeletal screening, evaluation and referral of injuries and management of injuries as may be deemed necessary or advisable by St. Luke's personnel in the treatment and diagnosis of my child.

I understand that this consent will remain in effect until my child ceases to be a member of the Program or until this consent is revoked by me by sending a written notification to St. Luke's, 1441 Schoenersville Road, Bethlehem, PA 18018, Attention: Senior Network Administrator, Sports Medicine Relationships.

FREE CHOICE OF PROVIDER

Nothing contained in this consent form shall in any way require or suggest that a child shall be required to seek care with St. Luke's, any Physician, or any affiliate of St. Luke's at any time whatsoever. Families are free to seek care for any injury/illness at any hospital, health care facility, provider, or physician. Nothing contained in this consent is intended to require and nothing herein shall be construed to require the family or the Program to make or influence referrals to, or otherwise generate business for, St. Luke's, any Physician, or any affiliate of St. Luke's.

Child's Name: _____ **Date of Birth:** _____

_____ **Relationship:** _____

Parent / Legal Guardian Name (*print*)

_____

Parent / Legal Guardian Address: (*print*)

City: _____ State: _____ Zip: _____

Parent/Legal Guardian Emergency Contact Number (First): _____

Parent/Legal Guardian Signature: _____ **Date:** _____

PATIENT LABEL AREA

St Luke's
UNIVERSITY HEALTH NETWORK

MEDICINA DEPORTIVA Y ATENCIÓN ORTOPÉDICA
FORMULARIO DE CONSENTIMIENTO PARA TRATAMIENTO DE JÓVENES

FORMULARIO DE CONSENTIMIENTO PARA TRATAMIENTO

Yo soy el padre/madre/tutor legal del niño mencionado a continuación. Autorizo a St. Luke's University Health Network y a su personal a darle atención médica y tratamiento a mi hijo en las prácticas y juegos de _____ **(nombre del distrito escolar/programa)** (el "Programa") por parte de proveedores de atención médica adecuadamente calificados (entrenadores atléticos, fisioterapeutas, médicos, etc.). Dicha atención médica y dichos tratamientos pueden incluir la administración de primeros auxilios y el control inicial de lesiones, rehabilitación, examen musculoesquelético, evaluación y derivación de lesiones y el control de lesiones en la medida en que el personal de St. Luke lo considere necesario o aconsejable para el tratamiento y diagnóstico de mi hijo.

Comprendo que este consentimiento seguirá vigente hasta que mi hijo deje de ser miembro del Programa o hasta que yo revoque este consentimiento por medio del envío de una notificación escrita a St. Luke a la siguiente dirección: 1441 Schoenersville Road, Bethlehem, PA 18018, Attention: Senior Network Administrator, Sports Medicine Relationships.

LIBRE ELECCIÓN DE PROVEEDOR

En este formulario de consentimiento, no se exigirá ni sugerirá en ningún momento que un niño deba obtener atención médica de St. Luke, de algún médico o de alguna empresa vinculada con St. Luke. Las familias pueden buscar atención médica libremente en cualquier hospital, institución de atención médica, proveedor o médico por cualquier lesión/enfermedad. En este consentimiento, no se pretende exigir, ni se interpretará, que la familia o el Programa deba hacer o promover derivaciones o deba, de otra manera, generar negocios para St. Luke, para algún médico o para alguna empresa vinculada con St. Luke.

Nombre del niño: _____ **Fecha de nacimiento:** _____

_____ **Relación:** _____
Nombre del padre/madre/tutor legar (*en letra de imprenta*)

_____
Dirección del padre/madre/ tutor legal: (*en letra de imprenta*)

Ciudad: _____ Estado: _____ Código postal: ____

Número de contacto de emergencia del padre/madre/tutor legal (primero): ____ – _____ – ____

Firma del padre/madre/tutor legal: _____ **Fecha:** _____

PATIENT LABEL AREA

St Luke's
UNIVERSITY HEALTH NETWORK

HIPAA PRIVACY AUTHORIZATION FORM
SPORTS MEDICINE–YOUTH

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization to Disclose.** I authorize St. Luke's University Health Network and its affiliates ("St. Luke's") to use and disclose to _____ **(name of school district/ program)** (the "Program") health information about my child obtained by St. Luke's in providing health services to my child during participation in sports programs (practices and games). The health information to be disclosed includes any information that is relevant to my child's ability to participate in practices, games, and other sports-related activities.
2. **Purpose.** The purposes of such uses and disclosures may include communicating with my child's coaches, administrative staff, athletic trainers, school nurses, guidance counselors and other individuals that are affiliated with the Program about my child's: (i) prognosis and recommended activities following an injury; (ii) ability to participate in training, practices, games and other team activities; and (iii) other health-related matters related to my child's activity with the Program.
3. **Refusal to Sign.** I understand that I may refuse to sign this authorization. St. Luke's may not refuse to treat my child based on my refusal to sign this Authorization.
4. **Expiration of Authorization.** This Authorization shall be in force and effect for as long as my child participates in the Program. This Authorization will expire when my child is no longer in the Program. After this Authorization expires, St. Luke's may no longer use or disclose my child's health information for the purposes listed in this Authorization unless I sign a new Authorization. However, materials that were created prior to the expiration of this Authorization may continue to be used or disclosed for the purposes listed in this Authorization.
5. **Revocation of Authorization.** I understand that I may revoke this authorization at any time, in writing, except to the extent that St. Luke's has already relied on it in making a disclosure. If I wish to revoke this Authorization, I will send a written request to: St. Luke's Sports Medicine, 1441 Schoenersville Road, Bethlehem, PA 18018, Attention: Senior Director, Sports Medicine Relationships.
6. **Further Disclosure.** I understand that my child's health information is protected by a federal law known as HIPAA for as long as that information is maintained by St. Luke's. If I permit St. Luke's to disclose my child's health information by signing this Authorization, that health information will no longer be protected by HIPAA. The recipient of my child's health information (the Program) might re-disclose the health information it receives, but would be required to comply with privacy laws governing schools prior to any such re-disclosure.

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Parent or Guardian Printed Name Child's Name

_____
Relationship to Child

PATIENT LABEL AREA

St Luke's
UNIVERSITY HEALTH NETWORK

FORMULARIO DE AUTORIZACIÓN DE PRIVACIDAD DE CONFORMIDAD CON LA HIPAA MEDICINA DEPORTIVA-JÓVENES

Autorización para usar o divulgar información de salud protegida .
(Requerida por la Ley de Portabilidad y Responsabilidad del Seguro Médico, título 45 del Código de Regulaciones Federales (CFR, por sus siglas en inglés), partes 160 y 164)

1. **Autorización para la divulgación.** Autorizo a St. Luke's University Health Network y a sus empresas vinculadas ("St. Luke") a utilizar y revelarle a _____ **(nombre del distrito escolar/ programa)** (el "Programa") la información de salud de mi hijo obtenida por St. Luke en la prestación de servicios de salud durante su participación en programas deportivos (prácticas y partidos). La información de salud que se divulgará incluye cualquier información que sea relevante para la capacidad de mi hijo para participar en prácticas, juegos y otras actividades relacionadas con los deportes.

2. **Propósito.** Los propósitos de dichos usos y divulgaciones pueden incluir comunicarse con los instructores de mi hijo, con el personal administrativo del equipo, con los entrenadores atléticos, con los enfermeros escolares, con los consejeros y con otras personas que estén afiliadas al Programa, acerca de lo siguiente: (i) el diagnóstico y las actividades recomendadas para mi hijo luego de una lesión; (ii) la capacidad de participar en el entrenamiento, las prácticas, los juegos y otras actividades en equipo; y (iii) otros temas de salud relacionados con la actividad de mi hijo en el Programa.

3. **Negativa a firmar.** Comprendo que me puedo negar a firmar esta autorización. St. Luke no puede negarse a atender a mi hijo si me niego a firmar esta autorización.

4. **Vencimiento de la autorización.** Esta autorización tendrá vigencia y efecto mientras mi hijo participe en el Programa. Esta autorización dejará de tener validez cuando mi hijo deje de participar en el Programa. Después de que la autorización deje de tener validez, St. Luke no podrá utilizar o divulgar la información de salud de mi hijo para los propósitos que figuran en esta autorización, a menos que firme una nueva autorización. Sin embargo, los materiales que se hayan creado antes del vencimiento de esta autorización pueden continuar siendo usados o divulgados para los fines que se detallan en esta autorización.

5. **Revocación de la autorización.** Entiendo que puedo revocar esta autorización en cualquier momento, por escrito, excepto en la medida en que St. Luke ya haya realizado una divulgación a expensas de esta. Si quiero revocar esta autorización, enviaré una solicitud por escrito a la siguiente dirección: St. Luke's Sports Medicine, 1441 Schoenersville Road, Bethlehem, PA 18018, Attention: Senior Director, Sports Medicine Relationships.

6. **Divulgación adicional.** Entiendo que la información de salud de mi hijo está protegida por la ley federal conocida como Ley de Responsabilidad y Transferibilidad de Seguros Médicos (HIPAA, por sus siglas en inglés) en tanto dicha información sea mantenida por St. Luke. Si permito que St. Luke divulgue la información de salud de mi hijo mediante la firma de esta autorización, dicha información dejará de estar protegida por la HIPAA. El receptor de la información de salud de mi hijo (el Programa) puede volver a divulgar la información de salud que reciba, pero se exigirá el cumplimiento de las leyes de protección de la intimidad que rige para las escuelas antes de proceder a la divulgación.

_____ _____
Firma del padre, de la madre o del tutor legal Firma Fecha

_____ _____
Nombre en imprenta del padre, de la madre o del tutor legal Nombre del niño

_____
Relación con el niño

2023-2024 ImPACT Testing Instructions

ImPACT testing is an important part of the pre-participation physical information the athletic training staff needs to prepare for the athletic season. It helps us have a baseline for your child in the event that they sustain a concussion during the season. This **MUST** be completed before they can be added to the team roster. Please email or call us at the contact information provided at the bottom of this page if you have any questions or concerns!

Please read instructions before starting!

The ImPACT Test will be taken to analyze how your brain functions on a normal basis. If your child were to get a concussion, this test will aid healthcare professionals in the assessment and management of concussion. The ImPACT test will test the following brain functions:

- *Short term memory*
- *Long-term memory*
- *Speed and reaction time*

Please do your best! If you do not take this test seriously, your scores will be low and you will have to retake it. **Be FAST but be ACCURATE.**

1. Make sure the testing environment is quiet and distraction-free
2. All other programs and browser tabs should be closed.
3. You must complete the test in a single attempt in less than **45 minutes**.
4. Please complete the "additional demographics" of the ImPACT test.

Directions:

1. **Open in Google Chrome.** It will not work with Internet Explorer or Firefox.
2. Website link: **www.impacttestonline.com/testing**
3. Enter Customer Code: **AZYV8QSNXT**
4. Select **Fleetwood Area School District** in the "*Organization*" Drop Box
5. Click **Launch Baseline Test**.
6. Select Language and begin filling out Demographic Data and answer questions.
7. Please click "**Additional demographics**" after completion of first demographic section.
8. **If you receive email notification from email below, you will need to retake the ImPACT test.**

If you have any questions, please email christian.klucsarits@sluhn.org or heather.wood@sluhn.org or call (610) 944-1217 ext. 20154

Fleetwood Area School District
Student Athlete ImPACT Baseline Test Acknowledgment Form

"ImPACT, an FDA cleared online tool for baseline and post-injury concussion testing, measures visual and verbal memory, reaction time, and processing speed to help determine if a patient (ages 12-80) can safely return to activity." -ImPACT Applications

ImPACT testing is an important part of the pre-participation physical information that the athletic training staff needs to prepare for the athletic season. It helps the athletic training staff have a baseline for your son/daughter in the event that they sustain a concussion during the season. The ImPACT Test will be taken to analyze how the brain functions on a normal basis. If your son/daughter were to sustain a concussion, this test will aid healthcare professionals in the assessment and management of a concussion.

The ImPACT Baseline Test only needs to be taken ONE TIME per year by each student-athlete.

I acknowledge and confirm that I have completed the ImPACT Baseline Concussion Test in its entirety.

Name (Please Print): _____ Grade: _____

Sport(s) Participating In: _____

Student Signature: _____ Date: _____

I acknowledge and confirm that my son/daughter has completed the ImPACT Baseline Concussion Test in its entirety.

Parent Signature: _____ Date: _____

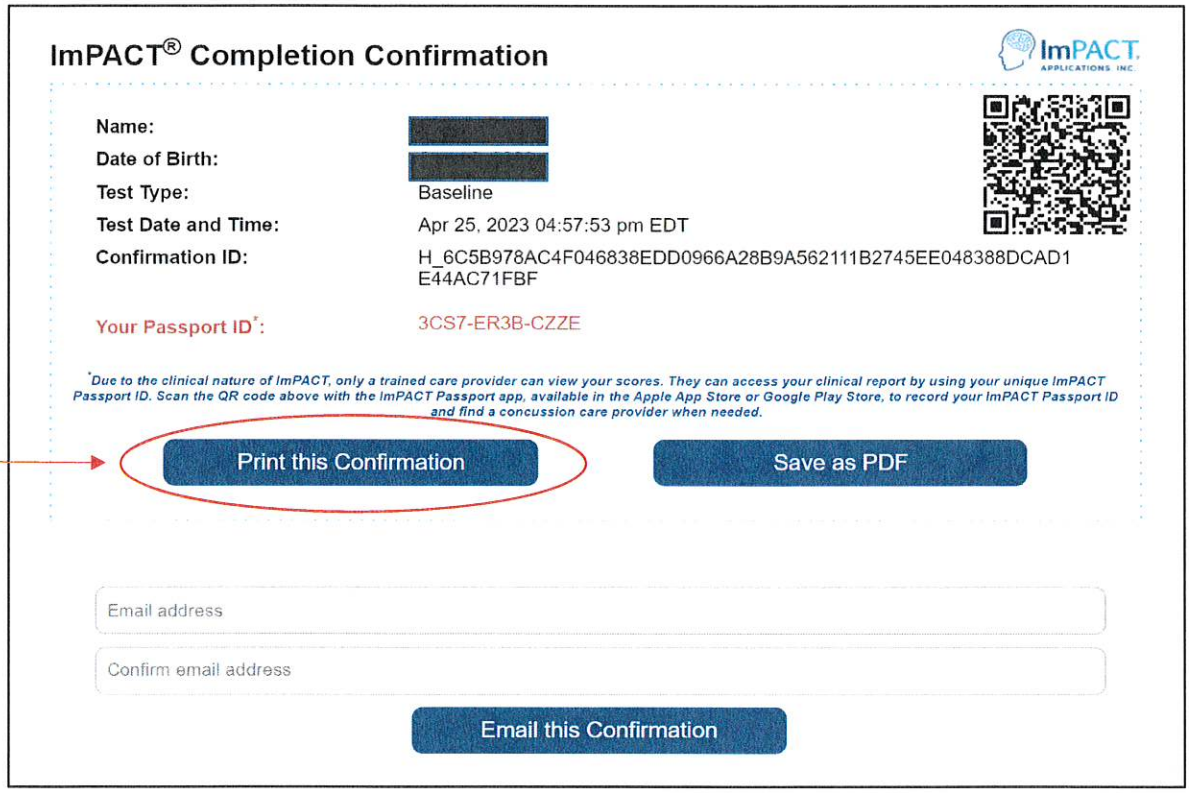
The St. Luke's Sports Medicine Concussion Policy can be found on the Fleetwood Athletics Website under the Sports Medicine Tab.

This form only needs to be filled out and signed one time per year for each athlete.

Questions/Concerns regarding the ImPACT Baseline Concussion Test should be directed to the Athletic Training Staff.

- heather.wood@sluhn.org
- christian.klucsarits@sluhn.org
- Office Phone: (610) 944-1247 ex. 20154

- Once the Baseline Test is complete, you will be taken to this page. Please click "Print this Confirmation" which is circled below.



- You will then be taken to your confirmation screen which looks like the image below. Please print this page and attach it with the rest of your PIAA Physical Packet to be added to the roster.