

**West Middlesex Area School District**  
**2020-2021 Pre-Participation Packet for Athletics**

Must be completed in its entirety in order for the student to be eligible to participate in any Junior High (Grades 7 & 8) or Varsity (Grades 9, 10, 11, and 12) sport at West Middlesex during the 2020-2021 school year. No exceptions.

This packet contains:

- A copy of the official ***PIAA Comprehensive Pre-Participation Physical Evaluation*** (no other physical evaluation form will be accepted).
- A copy of the ***Sharon Regional Medical Center Permission For Treatment***.

When this packet is completed with all signatures, dates, and documentation:

- Return it to the High School office in c/o the Athletic Director.
- There will be a bin labeled "Pre-Participation Packets". Place your packet in the bin.

**Name of Athlete:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Athlete's Grade for the 2020-2021 School Year (circle the appropriate grade):**    7    8    9    10    11    12

**Athlete's Date of Birth (Month/Day/Year):**    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Sport(s) to be participated in during the 2020-2021 school year:** \_\_\_\_\_

**Parent/Guardian Contact Information:**

**Name:** \_\_\_\_\_

**Relationship to Athlete:** \_\_\_\_\_

**Most Used Phone Number:** \_\_\_\_\_

**Most Used Email Address:** \_\_\_\_\_

**Preferred Method of Contact (Text/Call/Email):** \_\_\_\_\_

**DO NOT TAKE THIS PACKET APART**

**COMPLETE EVERY PORTION OF THIS PACKET AND SIGN EVERY PLACE THAT IS APPLICABLE.**

**Document 1 – Student Insurance:**

It is the policy of West Middlesex Area School District that all students involved in interscholastic sports must carry insurance and provide evidence of such coverage in order for the student to participate in their chosen sports.

A waiver must be signed by the parent/guardian absolving WMASD of all responsibility towards payment of any medical fees occurring as a result of any accident, illness, or injury that may occur while the athlete is actively engaged in athletics.

**To comply with WMASD policy, please check one of the following statements listed, then sign the portion below:**

\_\_\_\_\_ We will purchase school insurance that is offered on the WMASD website. ([www.wmasd.k12.pa.us](http://www.wmasd.k12.pa.us))

\_\_\_\_\_ We give permission for our son/daughter to participate in interscholastic sports and accept full responsibility for any accidents, illnesses, or injuries that may occur during participation in the sport for which he/she is involved. Our present insurance coverage is with:

\_\_\_\_\_ (Name of Insurance Company)

\_\_\_\_\_ (Policy Number)

Name of Athlete: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**\*\*PLEASE ATTACH A COPY (FRONT AND BACK) OF STUDENT-ATHLETE'S INSURANCE CARD ASSOCIATED WITH YOUR PRESENT INSURANCE COVERAGE THAT IDENTIFIES THE ATHLETE\*\***

**Document 2 – PIAA Comprehensive Initial Pre Participation Physical Exam (on following pages):**

The following document is the ONLY acceptable form for clearance to participate in interscholastic athletics in the state of Pennsylvania.



**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 1<sup>st</sup> and shall be effective, regardless of when performed during a school year, until the latter of the next May 31<sup>st</sup> 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](http://www.piaa.org), include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

C. **Disclosure of records needed to determine eligibility:** To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

D. **Permission to use name, likeness, and athletic information:** I consent to PIAA's use of the herein named student's name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

E. **Permission to administer emergency medical care:** I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

F. **CONFIDENTIALITY:** The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school's athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

#### What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body.
- Can change the way a student's brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been "dinged" or "had their bell rung."

All concussions are serious. A concussion can affect a student's ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student's brain time to heal.

#### What are the symptoms of a concussion?

Concussions cannot be seen; however, in a potentially concussed student, **one or more** of the symptoms listed below may become apparent and/or that the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

#### What should students do if they believe that they or someone else may have a concussion?

- **Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.
- **The student should be evaluated.** A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.
- **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

**How can students prevent a concussion?** Every sport is different, but there are steps students can take to protect themselves.

- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:
  - The right equipment for the sport, position, or activity;
  - Worn correctly and the correct size and fit; and
  - Used every time the student Practices and/or competes.
- Follow the Coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

**If a student believes they may have a concussion:** Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

### What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

### How common is sudden cardiac arrest in the United States?

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

### Are there warning signs?

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

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

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

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it.

### Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

#### *Information about SCA symptoms and warning signs.*

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may *also* hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

#### *Removal from play/return to play*

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Print Student-Athlete's Name

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Print Parent/Guardian's Name

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## SECTION 5: HEALTH HISTORY

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

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you ever had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that apply):			<b>CONCUSSION OR TRAUMATIC BRAIN INJURY</b> 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? <b>FEMALES ONLY</b> 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?		
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">           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?         </div> <div style="width: 45%;">           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:         </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">           Head Neck Shoulder Upper arm Elbow Forearm Hand/Fingers Chest            Upper back Lower back Hip Thigh Knee Calf/shin Foot/Toes         </div> <div style="width: 45%;">           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?         </div> </div>					

#s	Explain "Yes" answers here:

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

Student's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Enrolled in \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Brachial Artery BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ ) RP \_\_\_\_\_

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.

**Age 10-12:** BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: YES NO (circle one) Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		<input type="checkbox"/> Heart murmur <input type="checkbox"/> Femoral pulses to exclude aortic coarctation <input type="checkbox"/> Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

☐ **CLEARED**   ☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for: \_\_\_\_\_

☐ **NOT CLEARED** for the following types of sports (please check those that apply):

☐ COLLISION   ☐ CONTACT   ☐ NON-CONTACT   ☐ STRENUOUS   ☐ MODERATELY STRENUOUS   ☐ NON-STRENUOUS

Due to \_\_\_\_\_

Recommendation(s)/Referral(s) \_\_\_\_\_

AME's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

AME's Signature \_\_\_\_\_ MD, DO, PAC, CRNP, or SNP (circle one) Certification Date of CIPPE \_\_\_\_/\_\_\_\_/\_\_\_\_



## Sharon Regional Medical Center Permission For Treatment

Sharon Regional Medical Center's Sports Medicine Services has been contracted to provide sports medicine services for **WEST MIDDLESEX AREA SCHOOL DISTRICT** athletes.

Should an athlete become injured at a **WEST MIDDLESEX AREA SCHOOL DISTRICT** sanctioned activity where arrangements have been made to have certified athletic trainers on staff from Sharon Regional Medical Center present, the certified athletic trainer(s) will provide basic emergency first aid care services and screen the athlete for further treatment or referral to a physician.

Should a medical emergency occur, we will make every effort to contact you about treatment for your son or daughter. In the event that you cannot be contacted, we ask that you give us permission to provide emergency medical treatment.

**In the event that I cannot be contacted by telephone, I grant permission for the certified athletic trainer of Sharon Regional Medical Center to provide emergency treatment for:**

\_\_\_\_\_ (Son or Daughter)  
(Student-Athletes Name)

**Parent/Guardian PRINT NAME:** \_\_\_\_\_

**Parent/Guardian SIGNATURE:** \_\_\_\_\_

Contact Phone Numbers: HOME: \_\_\_\_\_ (Parent/Guardian)

Work (Dad) \_\_\_\_\_  
(or male guardian)

Work (Mom) \_\_\_\_\_  
(or female guardian)

Cell (Dad) \_\_\_\_\_  
(or male guardian)

Cell (Mom) \_\_\_\_\_  
(or female guardian)

Sharon Regional Health System  
Sports Medicine Services  
2360 Highland Road  
Hermitage, PA 16148

