FREQUENTLY ASKED QUESTIONS ABOUT SPORTS PHYSICALS

1. Why do I need a sports physical?

All student-athletes are required by the PIAA (Pennsylvania Interscholastic Athletic Association) to have a physical examination prior to participation in any school sponsored athletic activity.

2. When and where are sports physicals?

Sports physicals are typically offered at the Lampeter-Strasburg High School on the first Saturday in June. This is the ONLY time that sports physicals will be offered at L-S for the forthcoming school year.

3. How much does an L-S sponsored sports physical cost?

$10.

4. How long is a sports physical valid?

Physicals for the forthcoming school year must take place on or after June 1. Physicals completed before June 1 will not be accepted. A sports physical is valid from the date the doctor signs it until the following May 31.

5. Can I go to my own doctor for the sports physical?

Yes.

6. What is a CIPPE form?

CIPPE stands for Comprehensive Initial Pre-participation Physical Examination.

7. Can I use a different form?

No. The PIAA requires all student-athletes to use the CIPPE form.

8. Will I need another sports physical for a winter or spring sport?

No. Once a completed CIPPE form (sections 1-6) is on file, a second physical is not needed. However, a re-certification form will be required.

9. What is a re-certification?

Re-certification is required for all student-athletes participating in subsequent sports in the same school year, or if the initial sports physical took place earlier than 6 weeks prior to the start of the winter or spring sports season.

CIPPE Section 7 Parent/Guardian Re-certification Form
This is required for ALL athletes whose sports physical took place on or after June 1 but earlier than six weeks prior to the start of the winter or spring sports season.

CIPPE Section 8 Doctor Re-certification Form
This is ONLY required for athletes who see a healthcare provider for an injury or illness occurring after the sports physical but prior to the start of the subsequent sports season.
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 current 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 __________________________
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.

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<thead>
<tr>
<th>Fall Sports</th>
<th>Signature of Parent or Guardian</th>
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<tr>
<td>Cross Country</td>
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<td>Field Hockey</td>
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<td>Football</td>
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<td>Golf</td>
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<td>Soccer</td>
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<td>Girls’ Tennis</td>
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<td>Girls’ Volleyball</td>
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<td>Water Polo</td>
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<td>Other</td>
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<tr>
<th>Winter Sports</th>
<th>Signature of Parent or Guardian</th>
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<td>Basketball</td>
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<td>Bowling</td>
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<td>Competitive Spirit Squad</td>
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<td>Girls’ Gymnastics</td>
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<td>Rifle</td>
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<td>Swimming and Diving</td>
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<td>Track &amp; Field (Indoor)</td>
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<td>Wrestling</td>
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<tr>
<th>Spring Sports</th>
<th>Signature of Parent or Guardian</th>
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<td>Baseball</td>
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<td>Boys’ Tennis</td>
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<td>Track &amp; Field (Outdoor)</td>
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<td>Boys’ Volleyball</td>
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<td>Other</td>
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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____/____/_____

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<th>Summer Sports</th>
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<th>Other Sports</th>
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<th>Other Sports</th>
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<td>Other</td>
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**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
SECTION 5: HEALTH HISTORY

Explain “Yes” answers at the bottom of this form.
Circle questions you don’t know the answers to.

1. Has a doctor ever denied or restricted your participation in sport(s) for any reason? □ Yes □ No
2. Do you have an ongoing medical condition (like asthma or diabetes)? □ Yes □ No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? □ Yes □ No
4. Do you have allergies to medicines, pollens, foods, or stinging insects? □ Yes □ No
5. Have you ever passed out or nearly passed out DURING exercise? □ Yes □ No
6. Have you ever passed out or nearly passed out AFTER exercise? □ Yes □ No
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? □ Yes □ No
8. Does your heart race or skip beats during exercise? □ Yes □ No
9. Has a doctor ever told you that you have (check all that apply): □ High blood pressure □ Heart murmur □ Heart infection
   □ High cholesterol □ Heart attack

10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) □ Yes □ No
11. Has anyone in your family died for no apparent reason? □ Yes □ No
12. Does anyone in your family have a heart problem? □ Yes □ No
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50? □ Yes □ No
14. Does anyone in your family have Marfan syndrome? □ Yes □ No
15. Have you ever spent the night in a hospital? □ Yes □ No
16. Have you ever had surgery? □ Yes □ No

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? □ Yes □ No
   If yes, circle affected area below:

18. Have you had any broken or fractured bones or dislocated joints? □ Yes □ No
   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? □ Yes □ No
   If yes, circle below:

20. Have you ever had a stress fracture? □ Yes □ No

21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? □ Yes □ No

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? □ Yes □ No
24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? □ Yes □ No
25. Is there anyone in your family who has asthma? □ Yes □ No
26. Have you ever used an inhaler or taken asthma medicine? □ Yes □ No
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? □ Yes □ No
28. Have you had infectious mononucleosis (mono) within the last month? □ Yes □ No
29. Do you have any rashes, pressure sores, or other skin problems? □ Yes □ No
30. Have you ever had a herpes skin infection? □ Yes □ No

CONCUSSION OR TRAUMATIC BRAIN INJURY

31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? □ Yes □ No
32. Have you been hit in the head and been confused or lost your memory? □ Yes □ No
33. Do you experience dizziness and/or headaches with exercise? □ Yes □ No
34. Have you ever had a seizure? □ Yes □ No
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? □ Yes □ No
36. Have you ever been unable to move your arms or legs after being hit or falling? □ Yes □ No
37. When exercising in the heat, do you have severe muscle cramps or become ill? □ Yes □ No
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? □ Yes □ No
39. Have you had any problems with your eyes or vision? □ Yes □ No
40. Do you wear glasses or contact lenses? □ Yes □ No
41. Do you wear protective eyewear, such as goggles or a face shield? □ Yes □ No
42. Are you unhappy with your weight? □ Yes □ No
43. Are you trying to gain or lose weight? □ Yes □ No
44. Has anyone recommended you change your weight or eating habits? □ Yes □ No
45. Do you limit or carefully control what you eat? □ Yes □ No
46. Do you have any concerns that you would like to discuss with a doctor? □ Yes □ No

FEMALES ONLY

47. Have you ever had a menstrual period? □ Yes □ No
48. How old were you when you had your first menstrual period? □ Yes □ No
49. How many periods have you had in the last 12 months? □ Yes □ No
50. Are you pregnant? □ Yes □ No

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_____

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<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
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<tbody>
<tr>
<td>Appearance</td>
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<tr>
<td>Hearing</td>
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<td>Lymph Nodes</td>
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<td>□ heart murmur □ Femoral pulses to exclude aortic coarctation □ Physical stigmata of Marfan syndrome</td>
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<td>Foot/Toes</td>
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I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student’s HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student’s parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

- [ ] CLEARED  [ ] CLEARED, with recommendation(s) for further evaluation or treatment for:
- [ ] NOT CLEARED for the following types of sports (please check those that apply):
  - [ ] COLLISION  [ ] CONTACT  [ ] NON-CONTACT  [ ] STRENUOUS  [ ] MODERATELY STRENUOUS  [ ] NON-STRENUOUS
  Due to ________________________________________________

Recommendation(s)/Referral(s) ____________________________________________

AME’s Name (print/type) ________________________________ License # ____________________
Address ____________________________________________ Phone (_____ ) ______________

AME’s Signature ____________________________ MD, DO, PAC, CRNP, or SNP (circle one) Certification Date of CIPPE _____/_____/_____
SECTION 7: RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal, or the Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY.

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

SUPPLEMENTAL HEALTH HISTORY

Student's Name ____________________________________________________ Male/Female (circle one)

Date of Student's Birth: _____/_____/_______ Age of Student on Last Birthday: ______ Grade for Current School Year: ______

Winter Sport(s): ______________________________ Spring Sport(s):________________________

CHANGES TO PERSONAL INFORMATION (In the spaces below, identify any changes to the Personal Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Current Home Address ______________________________

Current Home Telephone # ( )___________________ Parent/Guardian Current Cellular Phone # ( )___________________

CHANGES TO EMERGENCY INFORMATION (In the spaces below, identify any changes to the Emergency Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Parent/s/Guardian's Name________________________________________ Relationship________________________

Address ______________________________ Emergency Contact Telephone # ( )___________________

Secondary Emergency Contact Person's Name________________________ Relationship________________________

Address ______________________________ Emergency Contact Telephone # ( )___________________

Medical Insurance Carrier ______________________________ Policy Number ______________________________

Address ______________________________ Telephone # ( )___________________

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

Address ______________________________ Telephone # ( )___________________

SUPPLEMENTAL HEALTH HISTORY:

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

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? [ ] Yes [ ] No

2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? [ ] Yes [ ] No

3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? [ ] Yes [ ] No

4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? [ ] Yes [ ] No

5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills? [ ] Yes [ ] No

6. Do you have any concerns that you would like to discuss with a physician? [ ] Yes [ ] No

#’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 question(s) 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________
INSTRUCTIONS
Pursuant to the Weight Control Program adopted by PIAA, prior to the participation by any student in interscholastic wrestling, the Minimum Wrestling Weight (MWW) at which the student may wrestle during the season must be (1) certified to by an Authorized Medical Examiner (AME) and (2) established NO EARLIER THAN six weeks prior to the first Regular Season Contest day of the wrestling season and NO LATER THAN the Monday preceding the first Regular Season Contest day of the wrestling season (See NOTE 1). This certification shall be provided to and maintained by the student’s Principal, or the Principal’s designee.

In certifying to the MWW, the AME shall first make a determination of the student’s Urine Specific Gravity/Body Weight and Percentage of Body Fat, or shall be given that information from a person authorized to make such an assessment (“the Assessor”). This determination shall be made consistent with National Federation of State High School Associations (NFHS) Wrestling Rule 1, Competition, Section 3, Weight-Control Program, which requires, in relevant part, hydration testing with a specific gravity not greater than 1.025, and an immediately following body fat assessment, as determined by the National Wrestling Coaches Association (NWCA) Optimal Performance Calculator (OPC) (together, the “Initial Assessment”).

Where the Initial Assessment establishes a percentage of body fat below 7% for a male or 12% for a female, the student must obtain an AME’s consent to participate.

For all wrestlers, the MWW must be certified to by an AME.

Student’s Name ___________________________ Age _______ Grade _______
Enrolled in ____________________________ School

INITIAL ASSESSMENT
I hereby certify that I have conducted an Initial Assessment of the herein named student consistent with the NWCA OPC, and have determined as follows:

Urine Specific Gravity/Body Weight ________/_______ Percentage of Body Fat _________ MWW _________

Assessor’s Name (print/type) _____________________________________________ Assessor’s I.D. # ___________

Assessor’s Signature ___________________________________________ Date ___/___/___

CERTIFICATION
Consistent with the instructions set forth above and the Initial Assessment, I have determined that the herein named student is certified to wrestle at the MWW of ________________ during the 20____ - 20____ wrestling season.

AME’s Name (print/type) ___________________________ License # ___________

Address _____________________________________________________________________ Phone ( ______ ) ___________

AME’s Signature ___________________________ MD, DO, PAC, CRNP, or SNP Date of Certification ___/___/___

(circle one)

For an appeal of the Initial Assessment, see NOTE 2.

NOTES:
1. For senior high school wrestlers coming out for the Team AFTER the Monday preceding the first Regular Season Contest day of the wrestling season the OPC will remain open until January 15th and for junior high/middle school wrestlers coming out for the Team AFTER the Monday preceding the first Regular Season Contest day of the wrestling season the OPC will remain open all season.
2. Any athlete who disagrees with the Initial Assessment may appeal the assessment results one time by having a second assessment, which shall be performed prior to the athlete’s first Regular Season wrestling Contest and shall be consistent with the athlete’s weight loss (descent) plan. Pursuant to the foregoing, results obtained at the second assessment shall supersede the Initial Assessment; therefore, no further appeal by any party shall be permitted. The second assessment shall utilize either Air Displacement Plethysmography (Bod Pod) or Hydrostatic Weighing testing to determine body fat percentage. The urine specific gravity testing shall be conducted and the athlete must obtain a result of less than or equal to 1.025 in order for the second assessment to proceed. All costs incurred in the second assessment shall be the responsibility of those appealing the Initial Assessment.
LAMPETER-STRASBURG SCHOOL DISTRICT

SPORTS EMERGENCY FORM

THIS FORM IS THE EMERGENCY FORM THAT WILL BE KEPT IN THE SPORTS TEAM MEDICAL KIT.
PLEASE PRINT CLEARLY IN INK.

Student Name__________________________ Date of Birth: __________ Grade____ Sport ________________

PERSONAL INFORMATION:

Street Address________________________________________ City______________________ Zip Code___________
Home Telephone_____________________
Parents/Guardians_____________________________________

Father’s Place of Work_______________________ Work Phone__________________ Cell Phone__________________
Mother’s Place of Work_______________________ Work Phone__________________ Cell Phone__________________

Family Physician________________________ Phone_________________ Hospital Preference____________________ Alternate
Person to Be Responsible for Child____________________________________ Phone____________________

INSURANCE COVERAGE:

All students participating in interscholastic athletics are supplied with student accident insurance by the school district with the terms of such covered dictated by the policy on file with the school district. The coverage provided is for an accident on the part of a student while participating in an interscholastic sport. The district supplied coverage is secondary to the parent’s coverage.

PARENT/GUARDIAN PERMISSION:

I grant permission for my child to have injuries treated by the athletic trainer and team physician and for medical personnel, at their discretion, to release school health record medical information to those individuals deemed necessary by the medical personnel. If a hospital is necessary, I grant permission to have my child transported to the nearest hospital, and I assume responsibility for fees incurred by such an emergency. I understand that the athletic trainer and the team physician have final authority to clear or to disqualify my child for activity following any injury or illness.

The information provided on this form is true and complete to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE ___________________________________ DATE ___________________

MEDICAL HISTORY:

Please explain any “YES” answers

YES NO EXPLAIN

Asthma ____________________________________________________________

Diabetes ____________________________________________________________

Heart Problems ______________________________________________________

Vision Problems _____________________________________________________

Food/Medication/Insect Allergies ______________________________________

History of Heat Illness _______________________________________________

Concussion History (dates, symptoms, length of recovery) ______________________________________

Special Medical Conditions (not otherwise listed) __________________________

Date of Most Recent Tetanus Immunization ___________________________________

PARENT/GUARDIAN SIGNATURE ___________________________________ DATE ___________________
LAMPETER-STRASBURG SCHOOL DISTRICT
SPORTS INJURY PROTOCOL
Please read the following policies. A signature from parent and student is required.

Sports Injury Protocol
All athletic injuries that occur during participation in school-sponsored sports must be reported to the athletic trainer. No coach may permit a student to return to participation in any athletic activity until the student is evaluated and cleared for return to participation in writing by an appropriate medical professional(s). The Board may designate a specific appropriate medical professional(s) to provide written clearance for return to participation. The District reserves the right to hold any student out of participation in an athletic activity if it is determined that the student is not ready to compete safely. The District should also consider requiring notification of the physical education teacher and removal from physical activity in physical education until written clearance is obtained.

Head Injury/Concussion Protocol
The Lampeter-Strasburg Athletic Department utilizes the computer based concussion management program ImPACT to assist with the supervision of head injuries sustained during athletic participation. The ImPACT test has been designed specifically for the management of sports-related concussions and measures multiple aspects of cognitive functioning, including working memory, sustained and selective attention time, non-verbal problem solving, and reaction time. ImPACT is currently the most widely utilized computerized program in the world and is implemented effectively across high school, collegiate, and professional levels of sport participation. For more information on the ImPACT test, please visit their website: www.impacttest.com

All student-athletes participating in a contact sport will take the ImPACT test prior to the beginning of the season in order to provide a baseline test. If a head injury is sustained during participation, the parent/guardian will be notified as well as the student’s physical education teacher. The student will again be tested on the ImPACT system and results compared with the baseline test. If a student shows any signs or symptoms of a concussion, the student will be excluded from athletic participation, including physical education class, until the following requirements are met:
1. The student has no concussion symptoms
2. The student completes an ImPACT test comparable to their baseline test
3. The student is cleared by the Lampeter-Strasburg athletic trainer and team physician.

The Lampeter-Strasburg athletic trainer and the team physician have final authority to clear or to disqualify a student for activity following any injury or illness.

Student-athletes in non-contact sports will not take a baseline ImPACT test. Therefore, if a head injury is sustained during participation, the parent/guardian will be notified as well as the student’s physical education teacher. The student will be excluded from participation, including physical education class, until the following requirements are met:
1. The student has no concussion symptoms
2. The student is cleared by the Lampeter-Strasburg athletic trainer and team physician

The Lampeter-Strasburg athletic trainer and the team physician have final authority to clear or to disqualify a student for activity following any injury or illness.

When the previous requirements are met, the student will initiate a 5-day return-to-play plan. This protocol has been developed using guidelines from the 2016 Berlin International Conference on Concussion in Sport.

Day 1: The student may participate in light aerobic exercise such as jogging or stationary cycling.
Day 2: The student may participate in more intense aerobic activity such as running sprints.
Day 3: The student may participate in practice with any non-contact training drills.
Day 4: The student may participate in a full contact practice.
Day 5: The student may return to full participation in practice and events.

If any symptoms occur after moving to a given level, the athlete should drop back down to the level at which he or she had been asymptomatic.

Please direct any questions to Jen McCrabb at 464-3311.

PLEASE READ THE BACK PAGE AND RETAIN THIS PAGE FOR FUTURE REFERENCE
A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

**WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?**

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports *one or more* symptoms of concussion listed below after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it’s OK to return to play.

### Symptoms observed by Coaches
- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can’t recall events prior to hit or fall
- Can’t recall events after hit or fall

### Symptoms reported by Athletes
- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, fuzzy, or groggy
- Concentration or memory problems
- Confusion
- Just not “feeling right” or “feeling down”

**CONCUSSION DANGER SIGN**

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull.

An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

**WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?**

If an athlete has a concussion, his/her brain needs time to heal. While an athlete’s brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. *They can even be fatal.*

**WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?**

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it’s OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

**REMEMBER**

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer. It is better to miss one game than the whole season. For more information visit: [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion).
LAMPETER-STRASBURG SCHOOL DISTRICT
SPORTS INJURY PROTOCOL

Please sign and date the following. This must be returned with the completed sports physical. Failure to complete and return this form will exclude the student-athlete from participation. Thank you.


Signature of Parent/Guardian ___________________________________________ Date ____________

Signature of Student ___________________________________________________ Date ____________

Print Name of Student _________________________________________________ Grade ____________

Sport ________________________________________ Date ____________