# 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 _____

_____

**Revised: March 22, 2017**

## SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

**The student's parent/guardian must complete all parts of this form.**

**A.** I hereby give my consent for _____ born on _____ who turned _____ on his/her last birthday, a student of _____ School and a resident of the _____ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____ - 20____ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

| Fall Sports | Signature of Parent or Guardian |
|---|---|
| Cross Country | |
| Field Hockey | |
| Football | |
| Golf | |
| Soccer | |
| Girls' Tennis | |
| Girls' Volleyball | |
| Water Polo | |
| Other | |

| Winter Sports | Signature of Parent or Guardian |
|---|---|
| Basketball | |
| Bowling | |
| Competitive Spirit Squad | |
| Girls' Gymnastics | |
| Rifle | |
| Swimming and Diving | |
| Track & Field (Indoor) | |
| Wrestling | |
| Other | |

| Spring Sports | Signature of Parent or Guardian |
|---|---|
| Baseball | |
| Boys' Lacrosse | |
| Girls' Lacrosse | |
| Softball | |
| Boys' Tennis | |
| Track & Field (Outdoor) | |
| Boys' Volleyball | |
| Other | |

**B. Understanding of eligibility rules:** I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent's/Guardian's Signature _____ Date____/____/_____

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

Parent's/Guardian's Signature _____ Date____/____/_____

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

Parent's/Guardian's Signature _____ Date____/____/_____

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

Parent's/Guardian's Signature _____ Date____/____/_____

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

Parent's/Guardian's Signature _____ Date____/____/_____

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

**What is a concussion?**
A concussion is a brain injury that:

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

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

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

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

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

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

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

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

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

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

Student's Signature _____ Date___/___/_____

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

Parent's/Guardian's Signature _____ Date___/___/_____

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

**What is sudden cardiac arrest?**

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

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

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

**Are there warning signs?**

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

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

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

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

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

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

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

*Information about SCA symptoms and warning signs.*

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

*Removal from play/return to play*

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

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

| | | |
|---|---|---|
| _____ | _____ | Date___/___/_____ |
| Signature of Student-Athlete | Print Student-Athlete's Name | |
| _____ | _____ | Date___/___/_____ |
| Signature of Parent/Guardian | Print Parent/Guardian's Name | |

Student's Name _____ Age_____ Grade_____

## SECTION 5: HEALTH HISTORY

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

| | | Yes | No |
|---|---|---|---|
| 1. | Has a doctor ever denied or restricted your participation in sport(s) for any reason? | ☐ | ☐ |
| 2. | Do you have an ongoing medical condition (like asthma or diabetes)? | ☐ | ☐ |
| 3. | Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | ☐ | ☐ |
| 4. | Do you have allergies to medicines, pollens, foods, or stinging insects? | ☐ | ☐ |
| 5. | Have you ever passed out or nearly passed out DURING exercise? | ☐ | ☐ |
| 6. | Have you ever passed out or nearly passed out AFTER exercise? | ☐ | ☐ |
| 7. | Have you ever had discomfort, pain, or pressure in your chest during exercise? | ☐ | ☐ |
| 8. | Does your heart race or skip beats during exercise? | ☐ | ☐ |
| 9. | Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection | | |
| 10. | Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) | ☐ | ☐ |
| 11. | Has anyone in your family died for no apparent reason? | ☐ | ☐ |
| 12. | Does anyone in your family have a heart problem? | ☐ | ☐ |
| 13. | Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50? | ☐ | ☐ |
| 14. | Does anyone in your family have Marfan syndrome? | ☐ | ☐ |
| 15. | Have you ever spent the night in a hospital? | ☐ | ☐ |
| 16. | Have you ever had surgery? | ☐ | ☐ |
| 17. | Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below: | ☐ | ☐ |
| 18. | Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | ☐ | ☐ |
| 19. | Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | ☐ | ☐ |

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

| | | | |
|---|---|---|---|
| 20. | Have you ever had a stress fracture? | ☐ | ☐ |
| 21. | Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | ☐ | ☐ |
| 22. | Do you regularly use a brace or assistive device? | ☐ | ☐ |

| | | Yes | No |
|---|---|---|---|
| 23. | Has a doctor ever told you that you have asthma or allergies? | ☐ | ☐ |
| 24. | Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? | ☐ | ☐ |
| 25. | Is there anyone in your family who has asthma? | ☐ | ☐ |
| 26. | Have you ever used an inhaler or taken asthma medicine? | ☐ | ☐ |
| 27. | Were you born without or are your missing a kidney, an eye, a testicle, or any other organ? | ☐ | ☐ |
| 28. | Have you had infectious mononucleosis (mono) within the last month? | ☐ | ☐ |
| 29. | Do you have any rashes, pressure sores, or other skin problems? | ☐ | ☐ |
| 30. | Have you ever had a herpes skin infection? | ☐ | ☐ |
| | **CONCUSSION OR TRAUMATIC BRAIN INJURY** | | |
| 31 | Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? | ☐ | ☐ |
| 32. | Have you been hit in the head and been confused or lost your memory? | ☐ | ☐ |
| 33. | Do you experience dizziness and/or headaches with exercise? | ☐ | ☐ |
| 34. | Have you ever had a seizure? | ☐ | ☐ |
| 35. | Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | ☐ | ☐ |
| 36. | Have you ever been unable to move your arms or legs after being hit or falling? | ☐ | ☐ |
| 37. | When exercising in the heat, do you have severe muscle cramps or become ill? | ☐ | ☐ |
| 38. | Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | ☐ | ☐ |
| 39. | Have you had any problems with your eyes or vision? | ☐ | ☐ |
| 40. | Do you wear glasses or contact lenses? | ☐ | ☐ |
| 41. | Do you wear protective eyewear, such as goggles or a face shield? | ☐ | ☐ |
| 42. | Are you unhappy with your weight? | ☐ | ☐ |
| 43. | Are you trying to gain or lose weight? | ☐ | ☐ |
| 44. | Has anyone recommended you change your weight or eating habits? | ☐ | ☐ |
| 45. | Do you limit or carefully control what you eat? | ☐ | ☐ |
| 46. | Do you have any concerns that you would like to discuss with a doctor? | ☐ | ☐ |
| | **FEMALES ONLY** | ☐ | ☐ |
| 47. | Have you ever had a menstrual period? | ☐ | ☐ |
| 48. | How old were you when you had your first menstrual period? | _____ | |
| 49. | How many periods have you had in the last 12 months? | _____ | |
| 50. | Are you pregnant? | ☐ | ☐ |

| #'s | Explain "Yes" answers here: |
|---|---|
| | |
| | |
| | |
| | |

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

Student's Signature _____ Date___/___/____

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

Parent's/Guardian's Signature _____ Date___/___/____

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

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

Student's Name _____ Age_____ Grade_____

Enrolled in _____ School Sport(s) _____

Height_____ Weight_____ % Body Fat (optional) _____ Brachial Artery BP_____/_____ (_____/_____ , _____/_____) RP_____

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

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

Vision: R 20/_____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal_____ Unequal_____

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

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

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

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

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

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type) _____ License #_____

Address_____ Phone (  )_____

AME's Signature_____MD, DO, PAC, CRNP, 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.**

| | Yes | No |
|---|---|---|
| 1. Since completion of the CIPPE, have you sustained an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? | ☐ | ☐ |
| 2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? | ☐ | ☐ |
| 3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? | ☐ | ☐ |
| 4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? | ☐ | ☐ |
| 5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills? | ☐ | ☐ |
| 6. Do you have any concerns that you would like to discuss with a physician? | ☐ | ☐ |

| #'s | Explain "Yes" answers here: |
|---|---|
| | |
| | |
| | |

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

Student's Signature _____Date___/___/_____

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

FALL SPORT_____ WINTER SPORT_____ SPRING SPORT_____

# Risk of Injury Acknowledgement Form

Cumberland Valley School District has provided you with a qualified coaching staff, protective equipment and qualified supportive sports medicine staff. Despite all efforts to minimize the risk of sports, athletes are seriously injured yearly in almost every sport. Be aware that every sport carries the inherent risk of catastrophic injury including but not limited to: blindness, paraplegia, quadriplegia, brain injury, sudden cardiac arrest or even death. Participants and their parents/guardians must accept this risk or they should not participate.

For your personal safety, it is imperative that you:

1. Inspect all of your equipment on a daily basis. Report any improperly fitting and/or faulty equipment to your coach or the athletic trainer immediately.

2. Know and observe the rules of the game; they are in place to protect you and other participants.

3. Become a better and safer athlete by listening to coaching instruction and learning proper technique.

4. Report all injuries and illnesses to the athletic trainer and/or team physician immediately. We cannot help you if we do not know you are injured or ill. (Informing us immediately is important for many reasons, including documentation for insurance and our records.)

5. Follow the advice of the athletic trainers/team physician regarding participation after illness/injury. **If you see a physician for any injury/illness, you may not return to practice or competition until the athletic training staff has received a note from the physician allowing you to participate.**

6. If an injury occurs, **do not move injured players or attempt to remove any gear.**

We have read the above statements and have discussed any questions we have with the coach and/or athletic trainers. I fully understand the risks involved in athletic participation at Cumberland Valley School District and we agree to abide by the listed standards.

_____

SIGNATURE OF ATHLETE DATE GRADE

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

The athletic trainer has my permission to provide the following medicines as needed after school hours. (During school hours athletes will be referred to the school nurse)

____Ibuprofen ____Acetaminophen ____Tums (antacid) ____ Benadryl

_____

SIGNATURE OF PARENT/GUARDIAN DATE EMAIL

**Cumberland Valley School District**
**6746 Carlisle Pike**
**Mechanicsburg, PA 17055**

# POLICY NO. 227: RANDOM DRUG TESTING AND BREATHALYZER TESTING GENERAL AUTHORIZATION AND CONSENT

We, the undersigned Student and Parent/Guardian, understand that the consumption of alcohol and the illegal use of controlled substances are unlawful activities which pose a substantial risk of harm to the Student and other members of the community. The Student hereby agrees to accept and abide by the standards, rules, and regulations set forth by Cumberland Valley School District Policy No. 227 (Drug Awareness/Paraphernalia). Under Policy No. 227, two procedures have been put in place to address the concerns about student use of drugs and alcohol: Random Drug Testing and Random Breathalyzer testing.

**RANDOM DRUG TESTING (applies to students participating in privileged activities)**
Student participation in athletics, extra-curricular activities, co-curricular activities, and driving to school is a privilege. The Student's participation in these activities and the reputation of the school are dependent, in part, on the Student's conduct as an individual. By signing this General Authorization and Consent, if the Student participates in athletics, an extra-curricular activity, a co-curricular activity, or receives driving privileges, the Student and Parent/Guardian hereby agree and consent to having the Student participate in random drug testing for the duration of time the Student participates in the activity.

The Student and Parent/Guardian also authorize Cumberland Valley School District to conduct, and hereby consent to, a test on a urine specimen which a Student randomly selected for testing will provide for the purpose of screening for drug use. We also authorize the release of information concerning the results of such a test to the Cumberland Valley School District and to the Parents and/or Guardians of the Student.

**RANDOM BREATHALYZER TESTING (applies to students participating in certain school social functions)**
Furthermore, the Student and Parent/Guardian acknowledge and understand that the Cumberland Valley School District has implemented random breathalyzer testing of students who attend certain school-related social functions, including but not limited to school dances, Winter Gala and the Prom. Students attending such social functions may be selected randomly for the purpose of undergoing breathalyzer testing prior to being permitted entry into the event. Breathalyzer testing will be performed by qualified individuals for the purpose of determining whether a student has consumed alcohol. The Student and Parent/Guardian hereby consent to Cumberland Valley School District administering a breathalyzer test to the Student that attends such a social function, in the event the Student is randomly selected for such test.

This also shall be deemed a consent pursuant to the Family Education Right to Privacy Act for the release of above information to the parties named above. These signatures signify consent to the standards, rules and regulations as set forth in Policy No. 227. Policy No. 227 is available upon request at the high school office or may be viewed on the district web site www.cvschools.org.

**NOTE:**
**Under Section II of Policy 227, only students participating in a privileged activity may be randomly drug tested; only students attending certain school social functions may be randomly breathalyzed.**

_____ Date: _____
Student Name (Please Print)

_____ Date: _____
Student Signature

_____ Date: _____
Parent or Guardian Signature

**For RANDOM DRUG TESTING Only**
PARENTS/GUARDIANS: Sign below if you would like to be present during the random drug testing process. Please understand you would need to be available during school hours and without prior warning. A phone call will be made and the testing process could take place within one half hour of the phone call. Write the phone number that should be called between 7:30 a.m. —2:30 p.m.

_____ _____
Signature Date Phone Number

csj:279753
12050-121

# CUMBERLAND VALLEY SCHOOL DISTRICT

6746 Carlisle Pike, Mechanicsburg, PA 17050-1796
Phone (717) 697-8261

## AUTHORIZATION TO DISCLOSE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Name of Student: _____

First Name Middle Initial Last Name

We, the above-named student (the "Student") and the parent(s)/legal guardian of the Student understand that as a condition of participation in the extracurricular activities at Cumberland Valley School District (the "District") every student of the District must consent to random drug testing, and any necessary repeat or follow-up testing to detect the illegal use of drugs. We understand that the random drug testing, and any necessary repeat or follow-up testing, will consist of the furnishing of a urine specimen which will be tested by the Department of Laboratory Medicine of Holy Spirit Hospital of the Sisters of Christian Charity ("Holy Spirit Hospital") for the presence of amphetamines, barbiturates, benzodiazepines, cocaine, marijuana, methadone, methaqualone, opiates, PCP and propoxyphene, and, at the District's request, anabolic steroids and other performance-enhancing drugs ("Controlled Substances").

We hereby authorize the Department of Laboratory Medicine of Holy Spirit Hospital and the physician serving as the Medical Review Officer (MRO) to report the results of the Student's drug test to the Student, the Student's parent(s)/legal guardian and the following employees of the Cumberland Valley School District:

- The Superintendent and Assistant Superintendent
- The Student's Building Principal
- The Student Assistance Team
- The Athletic Director, Coach, Program Director and Faculty Supervisor who supervises the student's participation in the athletic team, extra-curricular activity or co-curricular activity, as the case may be.

We further authorize the Department of Laboratory Medicine of Holy Spirit Hospital and the physician serving as the MRO to report to the above-listed persons the results of any repeat drug testing necessary due to specimen quality and the results of any follow-up testing to confirm a positive drug test or to confirm drug free status following entry into a drug assessment or drug treatment program.

The purpose of the reporting of the Student's drug test results to the Student, the Student's parent(s)/legal guardian, and the above-named employees of the District is to enforce the District policy that students participating in athletics, students participating in extracurricular and co-curricular activities, and students with driving privileges, be drug free, and to facilitate placement of students who test positive participate in a drug assessment or drug treatment program. This Authorization shall expire on the earlier of the date of the signing by the Student and the Student's parent(s) or legal guardian of another Authorization to Disclose Individually Identifiable Health Information intended for the same purposes stated in this Authorization, the date on which the Student's enrollment as a student in the District terminates or one (1) year from the date of this Authorization.

We understand that we have the right to revoke this Authorization by delivering to the Administrative Director of the Department of Laboratory Medicine of Holy Spirit Hospital, 503 North 21st Street, Camp Hill, Pennsylvania, 17011 a written statement stating our intent to revoke this Authorization. We also understand that our revocation will be effective immediately upon its receipt by the Administrative Director of the Department of Laboratory Medicine of Holy Spirit Hospital. We further understand that if we refuse to sign this Authorization, or if we revoke this Authorization, the Student will not participate in any drug testing and, therefore, will not be eligible for participation in the District's athletic program, extracurricular or co-curricular program, or for the driving privileges, for which the testing was required.

We understand the disclosure from Holy Spirit Hospital to the Student, the Student's parent(s)/legal guardian and the employees of the School District is subject to the privacy requirements of the regulations issued under the Health Insurance Portability and Accountability Act ("HIPAA"), 45 C.F.R. Part 164, Subpart E (Privacy of Individually Identifiable Health Information), and is therefore subject to disclosure only as set forth in the notice of privacy rights which we received along with this Authorization. We understand that after the information about the Student is disclosed by Holy Spirit Hospital to the District and ourselves, it is no longer protected by the HIPAA regulations from redisclosure by the District or ourselves to other parties. However, the District and Holy Spirit Hospital have agreed that the District will not disclose the results of any Student's drug test to any persons except those identified in this Authorization.

We hereby acknowledge that we have received a signed copy of this Authorization, and we have received a copy of Holy Spirit Hospital's Notice of Privacy Practices.

Student:

_____ _____

Date

Parent(s)/Legal Guardian (please circle applicable term):

_____ _____

Date

_____ _____

Date