✯ *UPDATE FOR SPORTS PARTICIPATION* ✯

PALMYRA AREA SCHOOL DISTRICT

Re-Certification Sports Physical Packet – Instructions to Parents & Guardians

STEP 1 – Please read and complete the following forms:

1. Athletic Department Information Form
2. Player Emergency Information Form
3. Section 7: Supplemental Health History
4. Section 8: To be completed only if the requirements listed in Step 3 are met.

STEP 2 – Re-Certification by Parent/Guardian

1. All healthy student-athletes who received a sports physical during the school year and completed the above-listed forms will automatically receive medical clearance to play a subsequent sport and do not need to receive a follow-up physical exam. These individuals do not need to see a physician prior to participation or complete "Section 8" of the re-certification packet.

STEP 3 – Re-Certification by Licensed Physician

1. Examination by a physician is necessary for re-certification if:
   a. Any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled.
   b. The student-athlete suffered a serious illness or injury requiring medical treatment from a physician since the original physical exam and has not provided written documentation pronouncing him or her physically fit to return to play.
2. If either scenario exists, "Section 8" of the re-certification packet must be completed by the examining physician prior to participation.

Note: In order to be eligible to participate, all the required forms must be completed and turned in to the athletic department prior to the first day of practice.

ATHLETIC DEPARTMENT INFORMATION

NAME:_____ SPORT:_____

DATE OF BIRTH:_____ AGE:_____ GRADE:_____

1. Please note the seasons of completion in the sport, beginning in 7th grade and including the current or upcoming year.

   Circle all grade levels that apply: 7 8 9 10 11 12

2. Please note if the student is homeschooled/cyber schooled. *(please circle)*

   ☐ YES ☐ No

3. Please note if the student is covered by health insurance provided by the parent/guardian.

   ☐ YES ☐ No

PLAYER EMERGENCY INFORMATION – *Coach's Copy For Away Events*

Athlete's Name:_____ Sport:_____

Date of Birth:_____ Age:_____ Home Phone: _____

Current Address:_____

( ) Contact Mother: Name_____ Work Phone_____ Cell_____

( ) Contact Father: Name_____ Work Phone_____ Cell_____

( ) Emergency Contact: Name_____ Phone_____

( ) Family Physician: Name_____ Phone_____

( ) Preferred Hospital:_____

( ) Insurance Information: Company_____ Policy #_____

( ) List any pertinent medications, allergies or medical conditions:_____

_____

In case of an emergency, I give permission for my child to receive emergency medical treatment.

Sign & Date Here:_____

(Parent/Guardian Signature) (Date)

SECTION 7: RE-CERTIFICATION BY PARENT/GUARDIAN

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

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

SUPPLEMENTAL HEALTH HISTORY

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

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

Winter Sport(s): _____ Spring Sport(s): _____

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

Current Home Address _____

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

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

Parent's/Guardian's Name_____ Relationship _____

Address _____ Emergency Contact Telephone # ( )_____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # ( )_____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Telephone # ( )_____

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

Address _____Telephone # ( )_____

SUPPLEMENTAL HEALTH HISTORY:

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

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

#'s	Explain "Yes" answers here:

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

Student's Signature _____Date____/____/_____

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

Section 8: Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine

This Form must be completed for any student who, subsequent to completion of Sections 1 through 6 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 8 may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to the Principal, or the Principal's designee, of the student's school, who, pursuant to ARTICLE X, LOCAL MANAGEMENT AND CONTROL, Section 2, Powers and Duties of Principal, subsection C, of the PIAA Constitution, shall "exclude any contestant who has suffered serious illness or injury until that contestant is pronounced physically fit by the school's licensed physician of medicine or osteopathic medicine, or if none is employed, by another licensed physician of medicine or osteopathic medicine."

NOTE: The physician completing this Form must first review Sections 5 and 6 of the herein named student's previously completed CIPPE Form. Section 7 must also be reviewed if both (1) this Form is being used by the herein named student to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in a subsequent sport season in the same school year AND (2) the herein named student either checked yes or circled any Supplemental Health History questions in Section 7.

If the physician completing this Form is clearing the herein named student subsequent to that student sustaining a concussion or traumatic brain injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.

Student's Name: _____ Age_____Grade_____

Enrolled in _____School

Condition(s) Treated Since Completion of the Herein Named Student's CIPPE Form: _____

_____

_____

_____

_____

A. GENERAL CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with no restrictions, except those, if any, set forth in Section 6 of that student's CIPPE Form.

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

Address_____ Phone ( )_____

Physician's Signature _____MD or DO *(circle one)* Date_____

B. LIMITED CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with, in addition to the restrictions, if any, set forth in Section 6 of that student's CIPPE Form, the following limitations/restrictions:

1. _____
2. _____
3. _____
4. _____

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

Address_____ Phone ( )_____

Physician's Signature _____MD or DO *(circle one)* Date_____