

TO: All Moon Area Student-Athletes and Parents/Guardians

DATE: January 4, 2010

SUBJECT: 2009 – 2010 Spring Physical Procedure FROM: Ricci Rich – Director of Athletics

The Pennsylvania Interscholastic Athletic Association (PIAA) has instituted a procedure whereby all student-athletes are mandated to have a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE) completed by an authorized medical examiner. All student-athletes are required to complete the PIAA physical examination known as CIPPE prior to the start of their sports season. All students interested in participating in athletics at Moon Area for the 2009 – 2010 school year are required **complete the entire Initial Physical Packet**. The Initial Packet is available in all school offices. **ONLY THESE FORMS WILL BE ACCEPTED, NO SUBSTITUTIONS.**

To be eligible to play a SPRING sport during the 2009 – 2010 school year, the initial CIPPE physical evaluation form must be completed no earlier than January 25, 2009, unless you participated in a fall or winter sport. This comprehensive evaluation can be performed at your family physician's office or with our school doctor. If you decide to have your primary care physician perform the physical evaluation, please check to ensure that the proper physical packet is completed, other forms or physicals **CANNOT BE ACCEPTED**. When making an appointment with your family doctor, please take all physical forms to the authorized medical examiner and have him/her fill out Section 4 of the evaluation. Please note – students who are participating in winter or spring sports should have their initial physicals conducted within 6 weeks of the start of their season. When a student is participating in a second or third sport throughout the school year, they do not need to obtain a new physical for the subsequent sports. **The physicals will be performed at Moon Middle School. The cost is \$10 per athlete. Checks should be made payable to: MASD** – Please write physicals in note area.

On the dates below, we will be conducting physicals for SPRING ACTIVITIES ONLY.

Schedule for SPRING School Physicals

Friday, February 19, 2010 Saturday, February 20, 2010

Boys-Grades 7-12 @3:00-4:30

Girls-Grades 7-12 @ 9:00-10:00

All forms must be sent directly to the Athletic Office, not the coach, prior to participation. Physicals turned in at the last minute may result in the student not being permitted to practice or to participate in tryouts. Such delays may result in a loss of tryout time or perhaps losing the opportunity to tryout completely. Once the physical is turned into the Athletic Office and reviewed for satisfactory completion, the student will be granted permission to participate in athletics. When a student-athlete has a desire to participate in a sport that has roster reductions or cuts, it is imperative that they have all of their paperwork submitted in a timely fashion.

For any athlete participating in multiple sports seasons, please follow the guidelines above for the initial CIPPE for the first sport season. For the 2nd or 3rd sport season, the parent/guardian and student will need to re-certify their contact information and health assessment, which include Sections 1 (Emergency Contact Info) & 5 (PIAA Re-Certification). Your doctor does not need to re-certify any information unless there has been a change in the student-athlete's health or if he/she has sustained a serious injury since the initial evaluation.

PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION

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INITIAL EVALUATION: Prior to any student participating in Practices, Scrimmages, and/or Contests, at any PIAA member school in the student's first sport in a 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 four Sections of the CIPPE Form. Upon completion of Sections 1, 2, and 3 by the parent/guardian, and Section 4 by an Authorized Medical Examiner, those Sections must be turned in to the Athletic Director for retention by the school. The CIPPE shall be performed no earlier than May 29th, 2009 and shall be effective for one school-year

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SECTION 1: PERSONAL AND EMERGENCY INFORMATION

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SPRING SPORT _____ LAST SPORT _____

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SPRING SPORT LEVEL: JV/VARSITY 9th 7/8 Date of Birth _____

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Student's Name _____ Gender: M / F Grade _____

Student's Name _____ Gender: M / F Grade _____

Current Physical Address _____

Current Physical Address _____

Current Home Phone # () _____

Current Home Phone # () _____

Parent/Guardian Current Cellular Phone # () _____

Parent/Guardian Current Cellular Phone # () _____

EMERGENCY INFORMATION

Primary Emergency Contact Person's Name _____

EMERGENCY INFORMATION

Primary Emergency Contact Person's Name _____

Relationship _____

Relationship _____

Address _____

Address _____

Emergency Contact Telephone # () _____

Emergency Contact Telephone # () _____ or () _____

Medical Insurance Carrier _____ Policy Number _____

Medical Insurance Carrier _____ Policy Number _____

Family Physician's Name _____, MD or DO

Family Physician's Name _____, MD or DO

Address _____ Telephone # () _____

Address _____ Telephone # () _____

Student's Allergies _____

Student's Allergies _____

Student's Health Condition(s) of Which an Emergency Physician Should be Aware

Student's Health Condition(s) of Which an Emergency Physician Should be Aware

Student's Prescription Medications _____

Student's Prescription Medications _____

PLEASE BE SURE TO COMPLETELY FILL OUT BOTH COPIES OF THE ABOVE FORM FOR RECORDS

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 Moon Area School District, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 2009 - 2010 school year in the sport as indicated by my signature(s) following the name of the said sport(s) approved below.

Sport	Signature of Parent or Guardian
Baseball (Spring)	
Softball (Spring)	
Track and Field (Spring)	
Boys Volleyball (Spring)	
Swimming 7/8 (Spring)	
Tennis (Spring)	
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 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.

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

Student's Name _____ Age _____ Grade _____

**Moon Area School District
Parental Notice and Agreement—Insurance Waiver (Due at Physical)**

**Injuries and Insurance in Physical Activities Program
Inaccordance with a practice established by the Moon Area Board of Education**

The Moon Area School District does not provide accident insurance protection for participants in any interscholastic athletic activity. However, it requires that participants in all of its interscholastic activities programs be protected by accident insurance provided by their parents/guardians. Therefore, parents/guardians are required to verify that they have accident insurance protection applicable to their child's participation in these programs.

Students participating in all interscholastic athletic activities *except Senior High Football*, may enroll in an accident insurance plan made available through the district, in conjunction with the Goodwin and Gruber Insurance Agency, telephone number: 366-5080, James Gruber, Agent. Parents desiring to enroll their child in this plan are encouraged to obtain information forms from the Principal's office.

Activity: _____

Name of Student Covered by this Agreement: _____

Said student is MY/OUR responsibility. If said student is not enrolled in the student accident insurance plan, I/WE will either not permit HIM/HER to participate in athletic activities or I/WE will promise insurance protection of MY/OUR own.

Please check one:

_____ The same is hereby enrolled in the student accident insurance plan.

_____ The same is covered in other insurance provided by ME/US and which I/WE consider adequate.

- A. If MY/OUR child is injured while participating in the interscholastic athletic program of the school, I/WE agree and promise as follows:
 - 1. To look only to such insurance benefits as there may be in the circumstances and
 - 2. To not look to the Moon Area School District or any of its personnel including members of the school board for any payment on any account.
- B. I/WE have explained the contents of this instrument to our child with the understanding and agreement on our parts generally that there shall be no participation in athletic programs of the school unless HE/SHE is enrolled in the student accident plan or unless the X is marked above for not enrolling and show that I/WE depend on MY/OUR own insurance and on MYSELF/OURSELVES.
- C. We intent to be legally bound.

Signature of Parent/Guardian _____ Date: _____

Student's Name _____ Birth Date: _____ Sport: _____ Grade _____

SECTION 3: HEALTH HISTORY

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

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that apply):			30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur			31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or Contest? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
Head Neck Shoulder Upper arm Elbow Forearm Hand/Fingers Chest			43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/Toes			44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
			FEMALES ONLY		
			47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
			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?	<input type="checkbox"/>	<input type="checkbox"/>

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 4: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

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

Student's Name _____ Age _____ Grade _____
 Height _____ Weight _____ % Body Fat (optional) _____ BP ____/____ (____/____, ____/____) RP _____

If either the 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		
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) _____

Authorized Medical Examiner's Name (print/type) _____ License # _____

Address _____ Phone () _____

Authorized Medical Examiner's Signature _____ MD, DO, PAC, CRNP, or SNP (circle one)

Date ____/____/____ (MUST BE AFTER MAY 28th, 2009 to be eligible for 2009-10 SCHOOL YEAR)

SECTION 5: PIAA RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed by the parent/guardian of any student who (1) completed a Comprehensive Initial Pre-Participation Physical Evaluation after May 29th, 2009 for participation in the student's first sport season of the current school year; AND (2) is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in SUBSEQUENT sport(s) in the same school year (WINTER OR SPRING). The Principal/Principal's designee must review the SUPPLEMENTAL HEALTH HISTORY and make a determination as to whether the student should be re-evaluated and re-certified by an Authorized Medical Examiner pursuant to Section 6.

SUPPLEMENTAL HEALTH HISTORY

Student's Name _____ Birth Date: _____ Grade _____

Current Home Address _____

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

SPRING SPORT _____

Last Sport Participated In _____

SPRING SPORT LEVEL: JV/VARSITY 9th 7/8

Last Sport Level: JV/VARSITY 9th 7/8

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

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Have you sustained an illness and/or injury related to sport(s) since completion of the CIPPE? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you sustained an illness and/or injury NOT related to sport(s) since completion of the CIPPE? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been confined to an institution and/or at home as a result of an illness and/or injury since completion of the CIPPE? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had surgery since completion of the CIPPE? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 5. Have you experienced dizzy spells, blackouts, and/or unconsciousness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you experienced any new health problems since completion of the CIPPE? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills since completion of the CIPPE? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |

#'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 ____/____/____

NOTE: If any **SUPPLEMENTAL HEALTH HISTORY** questions are either checked yes or circled, the Principal, or Principal's designee, of the herein named student's school shall require the student to complete Section 6 prior to being eligible to participate in sport(s) identified above.

THE STUDENT'S PARENT/GUARDIAN MUST COMPLETE ALL THE FOLLOWING:

A. I hereby give my consent for _____ born on _____ who turned _____ on his/her last birthday, a student of Moon Area School District, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 2009 - 2010 school year in the sport as indicated by my signature(s) following the name of the said sport(s) approved below.

Sport	Signature of Parent or Guardian
Baseball (Spring)	
Softball (Spring)	
Swimming & Diving	
Tennis	
Track & Field (Spring)	
Volleyball (Spring)	
Other	

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