LANCASTER
MENNONITE

Centered In Christ • Transforming Lives • Changing Our World

PHYSICAL PACKET CHECK-OFF SHEET

Dear Parent/Guardian,

Here is a helpful check-off sheet to make sure that your student will be ready and able to participate in the upcoming sports season at Lancaster Mennonite School. If you have any questions or concerns, please call the Athletic Trainer at 717-740-2450.

☐ **Section 7: Parent/Guardian Recertification Form**- ONLY *if participated in a previous sport season this year* ***or*** *if physical is not dated within 6 weeks prior to the first official day of practice*

☐ **Section 8: Physician Recertification Form**- ONLY *If answered "Yes" to a supplemental health history question on Section 7- Parent/Guardian Recertification Form*

☐ **Coaches Emergency Information Card - If information has change pleases fill out a new coaches information card.**

☐ **ImPACT Test-** *ONLY for student athletes in grades 9-12 and participating in the following sport: soccer, field hockey, basketball, softball, baseball, volleyball and lacrosse*

Thank you,

Cal Napolitano, LAT, ATC
Lancaster Mennonite School
Athletic Trainer

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.

	Question	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: ______________________________

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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_____________

LANCASTER MENNONITE
EMERGENCY INFORMATION CARD

Student's Name____ **Date of Birth** _________Age______ Grade____

Address ____

Mother ____ _______________________________
Name home phone

____ _______________________________
work phone cell

Father ____ _______________________________
Name home phone

____ _______________________________
work phone cell

Emergency #1____ _______________________________
Name home phone

____ _______________________________
work phone cell

Emergency #2 ____ _______________________________
Name home phone

____ _______________________________
work phone cell

Medical Insurance Carrier ____ Policy # _______________________

Address ____ Telephone # ( ) ____________________

Family Physician ____ Telephone # ( ) ____________________

Family Dentist ____ Telephone # ( ) ____________________

Student Allergies____

Asthma: YES NO **Inhaler:** YES NO **EPI Pen:** YES NO **Diabetic**: YES NO

Concussion: YES NO #: __________ Date of Last _______________

Other Health Condition (s) of which an Emergency Physician Should be Aware ______________________

____

Student's Prescription Medications ____

Student's immunizations ( ) Up to date ( ) Not up to date Specify ______________________________

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In the event I cannot be reached in an emergency, I hereby give permission to attending physician to hospitalize, secure proper treatment for and to order injections, anesthesia, or surgery for my child.

Parent/Gardian Signature____ Date _______________