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. Athletic forms are due one week prior to the first day of scheduled start date. If you have any questions or concerns, please call the Athletic Trainer at 717-740-2450.

- ☐ **PIAA Physical Form (Section 1-6)** - *Dated June 1st or later*
- ☐ **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*
- ☐ **Student Athlete Contract & Substance Abuse Policy for Co-Curricular Activities**
- ☐ **Coaches Emergency 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
2017-2018

# 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 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 _____

_____

## 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 ___/____/___

**Please read and sign both sides of this contract.**

# STUDENT ATHLETE CONTRACT

Participation in athletics is a privilege that carries additional responsibilities. As an athlete you are a leader and a representative of the school, your family, your church, and Jesus Christ. The following are expectations and regulations for LMH student athletes:

1. Complete all necessary paperwork before the first practice.

2. Give one hundred percent commitment to coach and team during practices and contests.

3. Maintain proper care of uniform and return within ten days of the final contest.

4. Maintain good grades and a positive citizenship record.
   --Fail no more than one class at the end of each week and at the end of a quarter.
   --School suspensions result in suspension from team.
   --Accumulation of offenses in school and/or on the field/court may result in game suspensions.

5. Report to school on time each day.

6. Demonstrate high levels of sportsmanship during practices and contests.
   --Talking back to officials and taunting players is not acceptable.
   --Profanity will not be tolerated.
   --Interact positively with opposing players, coaches, and officials before and after contests.

7. Ride the team bus to away games unless prior written permission is given by parents and approved by the coach. Players may ride home with parents from away contests after notifying the coach.

8. Expect no special treatment and take no special privileges because you are an athlete.

9. Assist in preparation of field, court, and equipment as requested by school staff.

10. Read and follow the covenant regarding illegal substances (on the back).

**STUDENT ATHLETE**
I count it a privilege to participate in interscholastic athletics. My signature indicates that I understand and am committed to upholding the standards and regulations contained in this contract and am willing to accept the consequences of my failure to meet these standards.

_____
student signature

**PARENT/GUARDIAN**
I am in agreement with the standards set forth in the player contract and will encourage my son/daughter to uphold them. I will support the school in the administration of its athletic program. Further, I commit myself as a spectator to be a positive representation of myself, LMS, and Jesus Christ; exemplifying Christ-like attitudes and behavior.

_____
parent/guardian signature

**Please read and sign both sides of this contract.**

# SUBSTANCE USE POLICY FOR CO-CURRICULAR ACTIVITIES

Lancaster Mennonite High School provides students the opportunity to participate in many co-curricular activities. Participation in such activities is a privilege, **not a right**, and carries additional responsibilities.

To protect the health and well being of our students and the integrity of the activity, LMH has established the following regulations to discourage substance use. Parents and school staff must work together to educate young people and discipline those who choose to use substances illegally.

This policy applies to any student involved in a co-curricular activity, leadership position, public performance or other activities related to school or under the supervision of school personnel. The following are prohibited: possession, use, or distribution of alcohol, tobacco, **a controlled substance**, or other drugs **illegally**; and **remaining present when any such activity occurs**. Any student determined to have violated this policy will be suspended from all co-curricular activities.

**This policy is in effect 24 hours a day 365 days a year while enrolled at LMH and participating in a co-curricular activity**. If a student violates the policy prior to their participation in an activity covered by this policy, the student may be declared ineligible for a period of time at the beginning of the activity in keeping with the policy.

If the offense occurs while the student is involved in a co-curricular activity, the suspension shall be for a period of forty (40) to sixty (60) calendar days from the date of the infraction. If the student is not currently in a co-curricular activity, the suspension time of forty (40) to sixty (60) days begins upon the start of their co-curricular participation. If the school year concludes before the suspension has been completed, the student will be ineligible for school related summer activities and the suspension will continue at the beginning of the next school year. Offenses occurring during the summer months will result in immediate removal from any school related activity and the forty (40) to sixty (60) calendar day suspension will begin the first day of school or for a fall co-curricular activity, the first day the activity meets. Students suspended for violation of these regulations are ineligible for any awards or recognition for the activity from which they were suspended. Officers of school organizations will be removed from their office for the year. During the suspension, students may not participate in any school activities which are not part of the instructional program including those that extend beyond the school day.

A suspension will be reduced to thirty calendar days upon completion of an approved substance abuse program. The cost of the program is the responsibility of the student. A suspended student must attend a conference with the principal, athletic director, advisor/coach and parent before returning to the activity.

Students involved with alcohol, tobacco or other drugs who have not been found in violation of this policy but who willingly seek help and follow through with corrective actions may be exempt from the sanctions of this policy, in the discretion of LMH.

Each subsequent offense will result in suspension from participation in all co-curricular activities for 365 days from date of infraction.

**LMH reserves the right to take additional disciplinary action, and to apply more or less severe penalties than the ones described in these guidelines, in its discretion.**

I have read and understand the policy and will work with the school to meet the standards for involvement in co-curricular activities.

_____
print name

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Grade | Student Signature | Sport | 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 _____

_____

_____

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 _____