

PHYSICAL CERTIFICATION CHECK OFF SHEET FOR ATHLETICS

Dear Parent/Guardian,

Please reference this check-off sheet to make sure that your student-athlete will be ready and able to participate in the upcoming sports season at Lancaster Mennonite School.

If you have any questions or concerns, please email the Athletic Trainer.

Only <u>ONE physical</u> is required <u>per school year</u>. Sports physicals must be completed <u>AFTER</u> <u>MAY 1st</u> of that <u>school year</u> and documented on <u>PIAA Section 6</u>. Physicals after May 1st can be used for that school year and student-athlete can recertify for each season.

<u>All forms must be completed</u> before the start of the season <u>to be eligible</u> for tryouts or practice. Please <u>write legibly</u>. *Be sure that all <u>forms</u> are <u>completed</u>, <u>signed</u>, and <u>dated</u>.*

FIRST sport of season for st	udent athlete = Full PIAA Physical Packet (Sections 1 -6)
Section 1: Personal and	Emergency Information *Include insurance information*
Section 2: Certification	of Parent/Guardian
Section 3: Understanding	g of Risk of Concussion and Traumatic Brain Injury
Section 4: Understanding	ng of Sudden Cardiac Arrest Symptoms and Warning Signs
Section 5: Health Histor	ry *Explain any "yes" answers*
Section 6: PIAA Comp	rehensive Pre-Participation Physical Evaluation *Signed & dated*
and 11 th grade) due to de	To be completed by new student athletes and repeated every 2 years (7 th , 9 th evelopment of the youth athlete. (Bowlers do NOT need to take SWAY). Lat <u>lancastermennonite.org/athletics/athletic-trainer/</u>
RE-CERTIFICATION Forms for	r winter/spring sports
Section 7: Re-certificat	ion by Parent/Guardian - If participated in a previous sport season
this school year and turn	ned in physical already OR if physical was completed prior to 6
weeks before the first of	ficial day of practice
Section 8: Re-certificat	ion by Physician - ONLY if answered "Yes" to any of the 6
supplemental health hist	tory question(s) on Section 7: Parent/Guardian

Re-certification forms can be completed as soon as **6 weeks before** the start of the season, not prior. If **physical exam** is completed prior to **6 weeks before** the start of the **winter/spring season** it must be **accompanied by** a **recertification form**, regardless of if they did not play a fall/winter sport. *Example #1. Fall student-athlete has physical and recertifies for winter/spring sport. Example #2: An athlete gets a physical in the summer, doesn't play a fall/winter sport, and recertifies for spring sport.*

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.

SUPPLEMENTA	L HEALTH HISTORY	
Student's Name	Male/Fem	nale (circle one
Date of Student's Birth:/ Age of Stude	ent on Last Birthday: Grade for Current School	Year:
Winter Sport(s):	_ Spring Sport(s):	
CHANGES TO PERSONAL INFORMATION (In the spaces be in the original Section 1: Personal and Emergency Information		ion set forth
Current Home Address		
Current Home Telephone # () Pa	arent/Guardian Current Cellular Phone # ()	
CHANGES TO EMERGENCY INFORMATION (In the spaces forth in the original Section 1: Personal and Emergency Information (In the spaces)		oformation se
Parent's/Guardian's Name	Relationship	
Parent/Guardian E-mail Address:		
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 I	DO (circle one)
Address	Telephone # ()	
completed Section 8, Re-Certification by Licensed Physician of Medithe student's school. 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 a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below 2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? #'s Explain yes answers; include injury, type of treatment from a licensed physician 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?	Yes No
I hereby certify that to the best of my knowledge all of the inform Student's Signature I hereby certify that to the best of my knowledge all of the inform 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 5 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 ar set forth below, I hereby authorize the above-identifie additional interscholastic athletics with no restrictions Form.	d student to participate for the remainder of the c	urrent school year i
Physician's Name (print/type)	License #	
Address	Phone ()
Physician's Signature	MD or DO (circle one)	Date
B. LIMITED CLEARANCE: Absent any illness and/forth below, I hereby authorize the above-identified additional interscholastic athletics with, in addition to Form, the following limitations/restrictions:	student to participate for the remainder of the cu	irrent school year i
1		
2		
3.		
4		
Physician's Name (print/type)	License #	:
Address	Phone ()
Physician's Signature	MD or DO (circle one) [Date