

CUMBERLAND VALLEY SCHOOL DISTRICT  
 INTERSCHOLASTIC EDUCATIONAL CO-CURRICULAR PROGRAM  
 2019-2020

TO: Athletes and Parents/Guardians  
 FROM: Athletic Department  
 DATE: April 19, 2019  
 SUBJECT: INTERSCHOLASTIC ATHLETIC PHYSICAL SCREENINGS

Dear Parents/Guardians:

On June 4<sup>th</sup> and 5<sup>th</sup>, from 6 to 8pm Cumberland Valley and Orthopaedic & Spine Specialists (OSS) will offer physicals to athletes participating in sports for the 2019-2020 school year. The line will begin outside the athletic office at the high school. The physical packet must be fully completed in order to proceed. The cost is \$15. **We accept cash or checks made out to CV Athletics.**

The Pennsylvania Interscholastic Athletic Association (PIAA) has developed procedures for obtaining a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE). This process is as follows:

- All athletes **MUST** have a completed 6-page physical packet, containing the CIPPE, dated June 1<sup>st</sup>, 2019 or later in order to be eligible to participate in interscholastic athletics during the 2019-2020 school year. Physicals dated prior to June 1<sup>st</sup>, 2019 **WILL NOT** be valid.
- The 6-page PIAA CIPPE packet can be obtained on the CV website under the Athletics page, then click Athletic Training, scroll to sports physical form. Additional forms needed: Risk of Injury form and Random Drug Testing forms.
- Please have a payment of **\$15 in cash or check** made out to the **CV Athletics**
- Physicals will take place at the high school, and the start line is outside the Athletic Office
- The physicals will be filed with the Athletic Trainers, please let us know at the check-in desk if you need a copy for your records.

**Co-curricular physical screenings, for students who will be in grades 7 through 12 and participating in interscholastic athletic programs during the 2019-2020 school year, will be conducted at Cumberland Valley High School according to the following schedule:**

<p><b>Tuesday – June 4, 2019</b>          (Athletes Last Name A through L)          6:00 – 6:30 PM – Athletes A-B-C          6:30 – 7:00 PM – Athletes D-E-F          7:00 – 7:30 PM – Athletes G-H-I          7:00 – 8:00 PM – Athletes J-K-L          *Physicals take at least an hour to be completed</p>	<p><b>Wednesday – June 5, 2019</b>          (Athletes Last Name M through Z)          6:00 – 6:30 PM – Athletes M-N-O          6:30 – 7:00 PM – Athletes P-Q-R          7:00 – 7:30 PM – Athletes S-T-U-V          7:30 – 8:00 PM – Athletes W-X-Y-Z          *Physicals take at least an hour to be completed</p>
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**All students are asked to wear shorts or loose fitting pants to be able to check the knee area**

Please Note: No appointment is necessary, just show up during your time slot. Students who do not show up as scheduled will be asked to wait until scheduled athletes are completed. If it is necessary that the time and/or date be changed you **MUST** contact Sheila Mueller (preferably by text) at 717-422-4737.

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**(INSTRUCTIONS FOR COMPLETION OF FORMS ARE ON THE REVERSED SIDE)**

## INSTRUCTIONS FOR COMPLETION OF ATHLETIC PACKET

**Section 1: Personal and Emergency Information** – This form provides information to the CV School District in the event of an emergency situation. Every student is required to complete this form and have it on file prior to participating in any interscholastic sport.

**Section 2: Certification of Parent/Guardian** – This form grants the athlete permission to participate in the CV Interscholastic Athletic programs.

(1) Parent or Guardian signatures are required beside **EACH SPORT** in which student intends to participate or “try-out”, and

(2) Parent or Guardian signatures are required on **FIVE LINES (B THROUGH F)** designated at the bottom of the form.

**Section 3: Understanding the Risk of Concussion and Traumatic Brain Injury** – This forms provides information on Concussions and Traumatic Brain Injuries that may be sustained as a part of participating in the CV Interscholastic Athletic program. Parent/ Guardian and Student must sign and date this form at the bottom.

**Section 4: Understanding the Risk of Sudden Cardiac Arrest Symptoms & Warning Signs** – This forms provides information on Sudden Cardiac Arrest Symptoms and Warning Signs that may be sustained as a part of participating in the CV Interscholastic Athletic program. Parent/ Guardian and Student must sign and date the bottom of this form.

**Section 5: Health History** – This form provides information that the doctors need before they conduct the physical exam. All questions must be answered and dates noted as requested.

**Section 6: PIAA Comprehensive Initial Pre-Participation Physical Evaluation and Certification of Authorized Medical Examiner** – This form is for the physical examination and must be signed by a PHYSICIAN. **This is the only form that will be accepted as a valid physical examination.** Please complete student’s name, age, grade, and sport at the top of the form prior to the exam.

**Additional forms needed: Risk of Injury form and the random drug testing forms**

**Section 7: Re-Certification Form** – this is needed for all athletes that participate in a winter and spring sport, unless their physical forms are dated at least 6 weeks prior to the try-out date (please read the top paragraph on section 7 for further information).

**Any Private Physical may not be administered prior to June 1, 2019 and must be completed on the Comprehensive Initial Pre-Participation Physical Form – Section 6.**

The first day of practice for each season is as follows:

**2019-2020**

**Fall Sports – August 12<sup>th</sup> (football Aug.5<sup>th</sup>)**

**Winter Sports – November 18<sup>th</sup>**

**Spring Sports – March 2<sup>nd</sup>**



**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 1<sup>st</sup> and shall be effective, regardless of when performed during a school year, until the latter of the next May 31<sup>st</sup> 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](http://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.

_____ Signature of Student-Athlete	_____ Print Student-Athlete's Name	Date ____/____/____
_____ Signature of Parent/Guardian	_____ Print Parent/Guardian's Name	Date ____/____/____

**SECTION 5: 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"/>	23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>					
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<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"/>					
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>					
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>					
5. Have you ever passed out or nearly passed out DURING 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"/>					
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<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"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>					
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you ever had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>					
9. Has a doctor ever told you that you have (check all that apply):			<b>CONCUSSION OR TRAUMATIC BRAIN INJURY</b>							
<input type="checkbox"/> High blood pressure			31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> High cholesterol			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> Heart murmur			33. Do you experience dizziness and/or headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> Heart infection			34. Have you ever had a seizure?	<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"/>	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"/>					
11. Has anyone in your family died for no apparent reason?	<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"/>					
12. Does anyone in your family have a heart problem?	<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"/>					
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	<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"/>					
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>					
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>					
16. Have you ever had surgery?	<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"/>					
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:	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you unhappy with your weight?	<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"/>	43. Are you trying to gain or lose weight?	<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"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>					
Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>				<b>FEMALES ONLY</b>			<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"/>				47. Have you ever had a menstrual period?			<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace or assistive device?	<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"/>

#'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		<input type="checkbox"/> Heart murmur <input type="checkbox"/> Femoral pulses to exclude aortic coarctation <input type="checkbox"/> 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 \_\_\_\_/\_\_\_\_/\_\_\_\_





Cumberland Valley School District  
6746 Carlisle Pike  
Mechanicsburg, PA 17055

**POLICY NO. 227: RANDOM DRUG TESTING AND BREATHALYZER TESTING  
GENERAL AUTHORIZATION AND CONSENT**

We, the undersigned Student and Parent/Guardian, understand that the consumption of alcohol and the illegal use of controlled substances are unlawful activities which pose a substantial risk of harm to the Student and other members of the community. The Student hereby agrees to accept and abide by the standards, rules, and regulations set forth by Cumberland Valley School District Policy No. 227 (Drug Awareness/Paraphernalia). Under Policy No. 227, two procedures have been put in place to address the concerns about student use of drugs and alcohol: Random Drug Testing and Random Breathalyzer testing.

**RANDOM DRUG TESTING** (applies to students participating in privileged activities)

Student participation in athletics, extra-curricular activities, co-curricular activities, and driving to school is a privilege. The Student's participation in these activities and the reputation of the school are dependent, in part, on the Student's conduct as an individual. By signing this General Authorization and Consent, if the Student participates in athletics, an extra-curricular activity, a co-curricular activity, or receives driving privileges, the Student and Parent/Guardian hereby agree and consent to having the Student participate in random drug testing for the duration of time the Student participates in the activity.

The Student and Parent/Guardian also authorize Cumberland Valley School District to conduct, and hereby consent to, a test on a urine specimen which a Student randomly selected for testing will provide for the purpose of screening for drug use. We also authorize the release of information concerning the results of such a test to the Cumberland Valley School District and to the Parents and/or Guardians of the Student.

**RANDOM BREATHALYZER TESTING** (applies to students participating in certain school social functions)

Furthermore, the Student and Parent/Guardian acknowledge and understand that the Cumberland Valley School District has implemented random breathalyzer testing of students who attend certain school-related social functions, including but not limited to school dances, Winter Gala and the Prom. Students attending such social functions may be selected randomly for the purpose of undergoing breathalyzer testing prior to being permitted entry into the event. Breathalyzer testing will be performed by qualified individuals for the purpose of determining whether a student has consumed alcohol. The Student and Parent/Guardian hereby consent to Cumberland Valley School District administering a breathalyzer test to the Student that attends such a social function, in the event the Student is randomly selected for such test.

This also shall be deemed a consent pursuant to the Family Education Right to Privacy Act for the release of above information to the parties named above. These signatures signify consent to the standards, rules and regulations as set forth in Policy No. 227. Policy No. 227 is available upon request at the high school office or may be viewed on the district web site [www.cvschools.org](http://www.cvschools.org).

# CUMBERLAND VALLEY HIGH SCHOOL

6746 Carlisle Pike • Mechanicsburg, PA 17050-1796  
717-697-8261

## AUTHORIZATION TO DISCLOSE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Name of Student: \_\_\_\_\_  
                                    First Name                    Middle Initial                    Last Name

We, the above-named student (the "Student") and the parent(s)/legal guardian of the Student understand that as a condition of participation in the extracurricular activities at Cumberland Valley School District (the "District") every student of the District must consent to random drug testing, and any necessary repeat of follow-up testing to detect the illegal use of drugs. We understand that the random drug testing, and any necessary repeat of follow-up testing, will consist of the furnishing of a urine specimen which will be tested by the Department of Laboratory Medicine of Geisinger Holy Spirit Hospital for the presence of amphetamines, barbiturates, benzodiazepines, cocaine, marijuana, methadone, methaqualone, opiates, PCP and propoxyphene, and at the District's request, anabolic steroids and other performance-enhancing drugs ("Controlled Substances.")

We hereby authorize the Department of Laboratory Medicine of Geisinger Holy Spirit Hospital and the physician serving as the Medical Review Officer (MRO) to report the results of the Student's drug test to the Student, the Student's parent(s)/legal guardian and the following employees of the Cumberland Valley School District:

- The Superintendent and Assistant Superintendent
- The Student's Building Principal
- The Student Assistance Team
- The Athletic Director, Coach, Program Director and Faculty Supervisor who supervises the student's participation in the athletic team, extra-curricular activity or co-curricular activity, as the case may be.

We further authorize the Department of Laboratory Medicine of Geisinger Holy Spirit Hospital and the physician serving as the MRO to report to the above-listed persons the results of any repeat drug testing necessary due to specimen quality and the results of any follow-up testing to confirm a positive drug test or to confirm drug free status following entry into a drug assessment or drug treatment program.

The purpose of the reporting of the Student's drug test results to the Student, the Student's parent(s)/legal guardian, and the above-named employees of the District is to enforce the District policy that students participating in athletics, students participating in extracurricular and co-curricular activities, and students with driving privileges, be drug free, and to facilitate placement of students who test positive participate in a drug assessment of drug treatment program. This Authorization shall expire on the earlier of the date of the signing by the Student and the Student's parent(s) or legal guardian of another Authorization to Disclose Individually Identifiable Health Information intended for the same purposes stated in the Authorization, the date on which the Student's enrollment as a student in the District terminates or one (1) year from the date of this Authorization.

We understand that we have the right to revoke this Authorization by delivering to the Administrative Director of the Department of Laboratory Medicine of Geisinger Holy Spirit Hospital, 503 North 21<sup>st</sup> Street, Camp Hill, Pennsylvania, 17011 a written statement stating our intent to revoke this Authorization. We also understand that our revocation will be effective immediately upon its receipt by the Administrative Director of the Department of Laboratory Medicine of Geisinger Holy Spirit Hospital. We further understand that if we refuse to sign this Authorization, or if we revoke this Authorization, the Student will not participate in any drug testing and, therefore, will not be eligible for participation in the District's athletic program, extracurricular or co-curricular program, or for the driving privileges, for which the testing was required.

We understand the disclosure from Geisinger Holy Spirit Hospital to the Student, the Student's parent(s)/legal guardian and the employees of the School District is subject to the privacy requirements of the regulations issued under the Health Insurance Portability and Accountability Act ("HIPAA"), 45 C.F.R. Part 164, Subpart E (Privacy of Individually Identifiable Health Information,) and is therefore subject to disclosure only as set forth in the notice of privacy rights which we received along with this Authorization. We understand that after the information about the Student is disclosed by Geisinger Holy Spirit Hospital to the District and ourselves, it is no longer protected by the HIPAA regulations from redisclosure by the District or ourselves to other parties. However, the District and Geisinger Holy Spirit Hospital have agreed that the District will not disclose the results of any Student's drug test to any persons except those identified in this Authorization

We hereby acknowledge that we have received a signed copy of this Authorization, and we have received a copy of Geisinger Holy Spirit Hospital's Notice of Privacy Practices.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent(s)/Legal Guardian (Please circle applicable term)

\_\_\_\_\_  
Date

