

Due to construction, the High School will be closed starting 6/13/11. Please mail forms to the Athletic Office, Pine-Richland High School, 700 Warrendale Road, Gibsonia, PA 15044, or put in an envelope and place in the "Sports Physicals" box in the **Middle School Lobby**.

PINE-RICHLAND SCHOOL DISTRICT
2011-2012 PRE-PARTICIPATION SPORTS PHYSICAL FORM

Dear Parents and/or Guardians:

We would like to take this opportunity to welcome you and your child to the athletic programs in the Pine-Richland School District. Please pay special attention to the information in this physical packet.

Please read all of the attached forms carefully. Follow all directions and **fill in the forms completely**. **Parents/Guardians must sign in 9 different places throughout the packet – see X's marked 1-9.**

There are 9 pages in this packet, including this cover letter. Pages 7 and 8 are UPMC Consent to Treat and HIPAA forms. Pine-Richland School District contracts athletic training services through UPMC Sports Medicine. These forms are required by the athletic training staff. **The pages labeled Sections 1, 2 and 3, and the UPMC forms must be completed and signed by the student-athlete and parent/guardian before obtaining the physical exam.** No exceptions will be made.

Pre-participation sports physicals for the 2011-2012 school year are being offered to all student-athletes in the Pine-Richland School District at no charge by the staff of Tri-Rivers Surgical Associates, Inc. Physical exams will be performed at Pine-Richland High School Stadium on

TUESDAY, JUNE 14, 2011

Please attend the Session as assigned by your Sport on page 2.

Please print out this form and bring the completed form with you on 6/14/11.

You may choose to have your child's pre-participation sports physical exam conducted at your private physician's office; the exam cannot have taken place prior to June 1, 2011; your physician must use the forms in this packet; and you must turn in the completed packet, signed by your physician to the High School Athletic Office by August 8, 2011 if playing a Fall Sport. **Your child will not be allowed to practice without a completed physical packet on file.** All pre-participation sports physical exams must take place within the Commonwealth of Pennsylvania. Out-of-state physical exams will not be accepted. Please mail forms to Athletic Office, Pine-Richland High School, 700 Warrendale Road, Gibsonia, PA 15044, or put in an envelope and place in the "Sports Physical" box in the Middle School Lobby.

All pre-participation physical exams must be completed using the forms in this packet. Other physical exam forms will not be accepted.

ATHLETIC INSURANCE INFORMATION: In the event that your child is injured, we would like to make certain that you are aware of school district procedures regarding injuries to athletes.

1. The school district has purchased accident insurance for students participating in the interscholastic athletic programs, cheerleading and band members. The insurance purchased by the school district covers the first \$100 of qualifying medical expenses.
2. After the first \$100, the student's family insurance, if any, becomes the primary insurance. Should the limits of the student's family insurance be exceeded, the insurance purchased by the school district will continue to cover qualifying medical expenses to the limits of the insurance.
3. In case of an athletic injury, the student or parent/guardian should obtain an insurance claim form from the Athletic Office and should complete it by following the printed directions, which accompany the claim form. The claim form must be submitted within ninety (90) days from the date of the injury to: Goodwin & Gruber Agency, Inc., Attn: James Gruber, 300 McKnight Park Drive, Pittsburgh, PA 15237.

Please retain this cover sheet for your records.

**Tuesday, June 14, 2011 – Sports Physicals for Fall, Winter, Spring
These are **GRADE LEVELS** for 2011-2012 SCHOOL YEAR**

Physicals may be done by your private physician over the summer after 6/1/11.

PRIVATE PHYSICIAN physicals must be turned into the Athletic Office by **8/8/11 if playing a Fall Sport**. Athletes participating in Winter or Spring sports that have had a physical; may turn it in when completed. The deadline for Winter sports is 11/11/11, and Spring sports is 2/27/12.

Anyone with an incomplete form and w/o approved parent signatures will not receive a physical.

8:00 am – 8:30 am: 7th – 12th – Boys Soccer / Girls Basketball / Baseball / Girls Volleyball
8:30 am – 9:15 am: 7th – 12th – Football / Boys Lacrosse
9:15 am – 9:30 am: 7th – 12th – Boys Basketball & 9th – 12th Boys Volleyball
9:30 am – 9:45 am: 7th – 12th – Girls Field Hockey / Girls Soccer
9:45 am – 10:15 am: 9th – 12th – B&G Tennis / Gymnastics / B&G Golf / Swimming / Diving
10:15 am – 10:30 am: 7th – 12th – Wrestling / Softball / 9th-12th Crew / Track
10:30 am – 10:45 am: 7th – 12th – Girls Lacrosse / Cheerleading / Fencing
10:45 am – 11:00 am: 7th-12th – Ice Hockey / In-Line Hockey / Cross Country

To expedite the large number of athletes, please have your physical form filled out prior to arriving.
DO NOT FORGET TO BRING YOUR FORMS – MUST BE FILLED OUT & COMPLETED BY A PARENT!

Student's Last Name: _____ First Name: _____

PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION

Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or contests, at any PIAA member school, the student is required to complete a physical evaluation. A student completing a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE) need not have a re-certification for a period of twelve (12) months, unless the student suffers a serious illness or injury within those twelve (12) months.

Students seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or contests through the CIPPE, must have the appropriate person(s) complete the first four Sections of this form

Section 1: Personal and Emergency Information

Please check here if physical was done by a Private Physician ___ Date _____ (must be after 6/1/11)

PERSONAL INFORMATION

ATHLETE'S NAME _____

SPORT: Fall _____ (name of sport) Due by 8/8/11

Winter _____ (name of sport) Due by 11/11/11

Spring _____ (name of sport) Due by 2/27/12

BIRTHDATE: _____ GRADE IN 2011-2012: _____ GENDER: _____

PARENTS (GUARDIAN) NAME: _____

HOME ADDRESS: _____ CITY _____ ZIP _____

HOME PHONE: _____ WORK PHONE MOM: _____ CELL MOM: _____

WORK PHONE DAD: _____ CELL DAD: _____

IN THE EVENT PARENTS CANNOT BE CONTACTED, PLEASE CONTACT:

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

Medical Insurance Carrier _____

Family Physician's Name _____ Telephone _____

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

Student Allergies: _____

Student's Prescription Medications: _____

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.

(1X)

Fall Sports	Signature of Parent or Guardian
Cross Country	
Field Hockey	
Football	
Golf	
Soccer	
Girls' Tennis	
Girls' Volleyball	
Water Polo	
Other	

(1X)

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Girls' Gymnastics	
Rifle	
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

(1X)

Spring Sports	Signature of Parent or Guardian
Baseball	
Lacrosse	
Girls' Soccer	
Softball	
Boys' Tennis	
Track & Field	
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 (2X) _____ 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 (3X) _____ 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 (4X) _____ 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 (5X) _____ Date ____/____/____

F. **Understanding of risk of concussion and head injury:** I hereby acknowledge that I am familiar with the nature and risk of concussion and head injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or head injury. Information relevant to concussion in high school sports is available on the PIAA Web site at www.piaa.org/piaa-for/sports-med

Parent's/Guardian's Signature (6X) _____ Date ____/____/____

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"/>	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 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):			CONCUSSION OR HEAD INJURY			
	<input type="checkbox"/> High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	31.	Have you ever had a concussion (i.e. bell rung, ding, head rush) or head injury?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	33.	Do you experience dizziness and/or headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Heart infection	<input type="checkbox"/>	<input type="checkbox"/>	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 died of heart problems or of 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, that 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 Ankle 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 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"/>	FEMALES ONLY			
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 (X) _____ 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 (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) _____ 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) _____

AME's Name (print/type) _____ License # _____

Address _____ Phone (_____) _____

AME's Signature _____ MD, DO, PAC, CRNP, or SNP (circle one) Date of CIPPE ____ / ____ / ____



UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)
Authorization for Release of Protected Health Information

RELEASE OF PROTECTED HEALTH INFORMATION

- I authorize UPMC to provide information related to my care to family/school/team physicians, school nurses, coaches, athletic directors, school principals, EMS personnel, and such other persons as needed for them to provide consultation, treatment, establish a plan of care or determine whether the Athlete may resume participation in school or sports activities.
I authorize UPMC to release my information for billing purposes.
I authorize UPMC (including its hospitals, other entities and programs) to use medical or other information maintained on electronic information systems or stored in various forms in connection with my care, health care operations, or payment for treatment and services.
I understand that the health record(s) released by UPMC may be re-disclosed by the facility/person that receives the record(s) and therefore (1) UPMC and its staff/employees has no responsibility or liability as a result of the re-disclosure and (2) such information may no longer be protected by federal or state privacy laws.
I understand that this Authorization is in effect for a period of one year from the date signed by the Athlete.
I understand that this Authorization is in effect if I am treated for an injury during off-season workouts; however, no time frame specified shall go beyond one year from the date of signature.
I understand that I have the right to revoke this Authorization form at any time by sending a written request to UPMC where the Authorization was provided.
I understand that my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
I understand that I am entitled to a copy of this completed Authorization form.

AGREED

Athlete/Patient Signature

Date

(B X)

Parent /Guardian Signature (If Athlete is a Minor)

Date

Relationship

UPMC Sports Medicine Representative Signature

Date



UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)
CONSENT FOR TREATMENT AND HEALTH CARE OPERATIONS (TPO)

I _____ (print or type name) consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic injuries. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team physician, school nurse, and licensed physical therapists. Under the direction of a certified athletic trainer, college/university student athletic trainers and high school student athletic trainers may also provide care.

I have been provided the UPMC Notice of Privacy Practices document. I also understand that additional copies of this Notice are available for my review upon my request. _____ Patient Initials

Patient signature _____ Date _____ UPMC Sports Medicine Representative _____

Patient signature _____ Date _____ _____

(9x) Signature/identify on behalf of patient/relationship _____ Date _____ UPMC Sports Medicine Representative _____

Signature/identify on behalf of patient/relationship _____ Date _____ UPMC Sports Medicine Representative _____

For Office Use Only:

Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices: _____

Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices:

BASELINE IMPACT TESTING NOTICE

Any student athlete going into grades 7th, 9th, or 11th, or any student athlete that has not previously been ImPACT tested must take a baseline ImPACT test on one of the sign up days listed below. Sign ups for baseline testing will be available at the school physical day Tuesday June 14, 2011. Any student athlete who does not have an updated baseline ImPACT test by the first day of practice will not be allowed to participate until completed. Baseline ImPACT testing is only available through the Pine Richland School District for school sponsored sports (Grades 7-12) contracted out to UPMC Sports Medicine. Student athletes receiving a physical through their private physician must have a ImPACT baseline test before the start of the season and are required to sign up for the dates below. If you have any questions regarding ImPACT testing please do not hesitate to contact the athletic training staff at **724-625-4444 ext 6825**. **Do not contact the athletic office, as they are not in charge of scheduling or answering questions about ImPACT testing.**

Thank You –PR Athletic Training Staff.

ImPACT Baseline Testing Dates

Located at PR Middle School rooms 100 and 409

7TH Grade Wednesday June 15 - 9 a.m., 10 a.m., 11 a.m., 12p.m., 1p.m., 2 p.m.

9TH Grade Thursday June 16 - 9 a.m., 10 a.m., 11 a.m., 12p.m., 1p.m., 2 p.m

11th Grade Friday June 17 - 9 a.m., 10 a.m., 11 a.m., 12p.m., 1p.m., 2 p.m

RESCHEDULING:

If there is a conflict on your scheduling date, please try and make arrangements with other student athletes in the same grade, as testing is being administered by grade levels on particular days. We expect to be testing over 800 student athletes over these 3 days, and we will not be able to accommodate to a large number of schedule changes.

