

CHANGES TO SPORTS PHYSICALS

Beginning with the 2010-2011 school year, there will be two important changes regarding sports physicals.

1) We will be instituting a \$15.00 charge for all physicals performed through Commonwealth Orthopedics whether the physical is done here at the high school, another participating high school, or at the office of Commonwealth Orthopedics in Exeter. Charges for the physicals done off site will be collected at the time the paperwork is handed in to the Athletic Office. Checks should be made payable to **Daniel Boone Area School District**.

2) We are planning on offering physicals only *once* during the school year. We are encouraging ALL athletes, regardless of sport or season, to attend the physicals on June 1st and 2nd. For instance, any athlete who only plays a winter or spring sport should still get his/her sports physical done in June. When the winter or spring season approaches they will only need to fill out a recertification form indicating that they have had no injuries since the physical. Any injuries reported on the recertification form must include a physician's note clearing him/her for participation.

REMINDERS:

* All sports physicals must be completed on the proper PIAA paperwork which can be found at www.dboone.org under 'Athletics'. We *will not accept* paperwork from a 'wellness visit', permit physical, etc.

* Physicals performed by your family doctor can be dated no earlier than June 1, 2010 for the 2010-2011 school year.

If you have any questions, please contact:

Athletic Department 610-582-6103

Bob Hartzell, ATC 484-256-3883 or hartzell@dboone.org

ATTENTION ATHLETES

Physicals for ALL sports will be held in the
HIGH SCHOOL GYM
JUNE 1st AND 2nd

THERE WILL BE A \$15.00 CHARGE FOR PHYSICALS

Please make checks payable to: Daniel Boone Area School District

To avoid long wait times, we will be conducting physicals
by grade.

June 1st - Middle School

5:00-6:30 – 7 th Grade	\	2010-2011
6:15-7:45 – 8 th Grade	-	school year
7:30-9:00 – 9 th Grade	/	

June 2nd – High School

4:00-5:30 – 10 th Grade	\	2010-2011
5:15-6:45 – 11 th Grade	-	school year
6:30-8:00 – 12 th Grade	/	

Please bring completed and signed forms with you during your assigned time slot.

** If you are going to have your physical completed by your family physician, this form *must* be turned into the Athletic Director's office no later than August 9th. Any paperwork turned in late may result in missed practice time.

NOTE: The PIAA will not accept a physical completed before
June 1st

DANIEL BOONE SPORTS MEDICINE EMERGENCY INFORMATION

(To be completed by a parent/guardian)

Please Print

FIRST NAME _____ MIDDLE _____ LAST _____ GRADUATION YEAR _____
ADDRESS _____ PHONE _____ MALE _____
CITY _____ STATE _____ ZIP _____ BIRTHDATE _____ FEMALE _____
PARENT'S/GUARDIAN NAME _____
SPORT PARTICIPATING IN: FALL _____ WINTER _____ SPRING _____
(Name of Sport) (Name of Sport) (Name of Sport)

EMERGENCY CONTACT 1 (Mother/Father/Guardian) · RELATIONSHIP _____
NAME _____ HOME PHONE _____
ADDRESS _____ WORK PHONE _____
CITY _____ STATE _____ ZIP _____ ALT. PHONE _____
EMERGENCY CONTACT 2 RELATIONSHIP _____
NAME _____ HOME PHONE _____
ADDRESS _____ WORK PHONE _____
CITY _____ STATE _____ ZIP _____ ALT. PHONE _____
***ALLERGIES (to food, medications, etc.): _____
Pre-Existing Circulatory/Pulmonary Conditions: _____
Inhalers: _____
Medications: _____
Other Pertinent Information: _____

THE FOLLOWING INFORMATION MUST BE COMPLETED PRIOR TO THE STUDENT PARTICIPATING:
INSURANCE COMPANY _____
POLICY # _____ GROUP# _____
HOSPITAL OF CHOICE _____
FAMILY DOCTOR _____ PHONE # _____
FAMILY DENTIST _____ PHONE # _____
FAMILY OPTOMETRIST _____ PHONE# _____

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.

Sport	Signature of Parent or Guardian
Baseball (Spring)	
Basketball (Winter)	
Bowling (Winter)	
Cross Country (Fall)	
Field Hockey (Fall)	
Football (Fall)	
Golf (Fall)	
Gymnastics (Winter)	
Lacrosse (Spring)	
Rifle (Winter)	
Soccer (Fall)	
Soccer-Girls (Spring)	
Softball (Spring)	
Swimming & Diving	
Tennis-Girls (Fall)	
Tennis-Boys (Spring)	
Track-Indoor (Winter)	
Track & Field (Spring)	
Volleyball-Girls (Fall)	
Volleyball-Boys (Spring)	
Water Polo (Fall)	
Wrestling (Winter)	
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 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.

Parent's/Guardian's Signature _____ 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"/>	22.	Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have an ongoing medical condition (like asthma or diabetes)?	<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"/>
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<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"/>
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	25.	Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever passed out or nearly passed out AFTER 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"/>
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28.	Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Does your heart race or skip beats 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"/>
9.	Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection	<input type="checkbox"/>	<input type="checkbox"/>	30.	Have you had a herpes skin infection?	<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"/>	31.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has anyone in your family died for no apparent reason?	<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"/>
12.	Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	33.	Have you ever had a seizure?	<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"/>	34.	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Does anyone in your family have Marfan syndrome?	<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"/>
15.	Have you ever spent the night in a hospital?	<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"/>
16.	Have you ever had surgery?	<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"/>
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"/>	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"/>
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	39.	Have you had any problems with your eyes or vision?	<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"/>	40.	Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
	Head Neck Shoulder Upper arm Elbow Forearm Hand/Fingers Chest			41.	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
	Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/Toes			42.	Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	43.	Are you trying to gain or lose weight?	<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"/>	44.	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
				45.	Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
				46.	Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
				FEMALES ONLY			
				47.	Have you ever had a menstrual period?	<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"/>

No(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 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 ____/____/____

Section 7: CIPPE MINIMUM WRESTLING WEIGHT

INSTRUCTIONS

Pursuant to the Weight Control Program adopted by PIAA, prior to the participation by any student in interscholastic wrestling, the Minimum Wrestling Weight (MWW) at which the student may wrestle during the season must be (1) certified to by an Authorized Medical Examiner (AME), and (2) established NO EARLIER THAN six weeks prior to the first Regular Season Contest day of the wrestling season and NO LATER THAN the Monday preceding the first Regular Season Contest day of the wrestling season. This certification shall be provided to and maintained by the student's Principal, or the Principal's designee.

In certifying to the MWW, the AME shall first make a determination of the student's Urine Specific Gravity/Body Weight and Percentage of Body Fat, or shall be given that information from a person authorized to make such an assessment ("the Assessor"). This determination shall be made consistent with National Federation of State High School Associations (NFHS) Wrestling Rule 1, Competition, Section 3, Weight-Control Program, which requires, in relevant part, hydration testing with a specific gravity not greater than 1.025, and an immediately following body fat assessment, as determined by the National Wrestling Coaches Association (NWCA) Optimal Performance Calculator, Scholastic Edition (together, the "Initial Assessment").

Where the Initial Assessment establishes a percentage of body fat below 7% for a male or 12% for a female, the student must obtain an AME's consent to participate.

For all wrestlers, the MWW must be certified to by an AME.

Student's Name _____ Age _____ Grade _____
Enrolled in _____ School _____

INITIAL ASSESSMENT

I hereby certify that I have conducted an Initial Assessment of the herein named student consistent with the NWCA Optimal Performance Calculator, Scholastic Edition, and have determined as follows:

Urine Specific Gravity/Body Weight _____/_____ Percentage of Body Fat _____ MWW _____

Assessor's Name (print/type) _____ Assessor's I.D. # _____

Assessor's Signature _____ Date ____/____/____

CERTIFICATION

Consistent with the instructions set forth above and the Initial Assessment, I have determined that the herein named student is certified to wrestle at the MWW of _____ during the 20____ - 20____ wrestling season.

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

Address _____ Phone () _____

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

NOTE: Any athlete who disagrees with the Initial Assessment may appeal the assessment results one time by having a second assessment performed. The second assessment must utilize either Air Displacement Plethysmography (Bod Pod) or Hydrostatic Weighing testing to determine body fat percentage. Results obtained at the second assessment shall supersede the Initial Assessment and are automatically accepted; no further appeal by any party is permitted. All costs incurred in the second assessment are the responsibility of those appealing the Initial Assessment. The urine specific gravity testing will be conducted and the athlete will need to have a result of less than or equal to 1.025 in order for the second assessment to proceed.