

**PINE-RICHLAND SCHOOL DISTRICT**  
**2008-2009 PRE-PARTICIPATION SPORTS PHYSICAL FORM**

**BE ADVISED – NEW PIAA PHYSICAL FORMS ATTACHED**  
**THE OLD SCHOOL DISTRICT PHYSICAL FORMS WILL NO LONGER BE ACCEPTED**

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. **These forms are different from the forms we have used in the past.** The **old forms will no longer be accepted** due to changes in PIAA regulations regarding pre-participation physical exams. Beginning with the fall sports for 2007 **only one physical exam will be required for each student-athlete per year.** (Some exclusions apply.)

Please read all of the attached forms carefully. Follow all directions and **fill in the forms completely.**  
**Parents/Guardians must sign in 8 different places throughout the packet.**

There are 8 pages in this packet, including this cover letter. Pages 6 and 7 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 2007-2008 school year are being offered to all student-athletes in the Pine-Richland School District at no charge by Dr. Agnew, Dr. Waltrip and Dr. Muzzonigro, along with the staff of Tri-Rivers Surgical Associates, Inc. Physical exams will be performed at Pine-Richland High School on the dates listed below. High School student-athletes: please return all pages of the physical packet to the High School Athletic Office. Middle School student-athletes: please return all pages of the physical packet to the Middle School Front Office. **The completed packets MUST be turned in PRIOR TO THE DATE OF PHYSICAL EXAMS. NO PACKETS WILL BE ACCEPTED ON THE DATE OF PHYSICAL EXAMS. Packets are due no later than May 27, 2008.**

If you choose to have your child's pre-participation sports physical exam conducted at your private physician's office: **the exam cannot take place prior to June 1, 2008 and after August 4, 2008;** 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 prior to the start of the first practice session for your child's sport. All pre-participation sports physical exams must take place within the Commonwealth of Pennsylvania. Out-of-state physical exams will not be accepted. **All pre-participation physical exams must be completed using the forms in this packet. Other physical exam forms will not be accepted.**

**2008-09 Fall Sports:  
8:00am to 10:30am**

**Middle School: Mon. June 2, 2008 in the Middle School Nurse's Office  
High School: Thurs. June 5, 2008 in the High School Athletic Training Room**

**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.**

**If you have any questions, please contact the Athletic Office at 724-625-4444 ext. 6800.**

**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**

**PERSONAL INFORMATION**

ATHLETE'S NAME \_\_\_\_\_

LIST SPORT YOU ARE PLAYING: Fall \_\_\_\_\_ Winter \_\_\_\_\_ Spring \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ GRADE: \_\_\_\_\_ 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 (Student) \_\_\_\_\_ born on \_\_\_\_\_ who turned \_\_\_\_\_ on his/her last birthday, a student of Pine-Richland Middle/High School and a resident of the Pine-Richland Public School District, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 2007 - 2008 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)	
Cheerleading	
Crew	
Cross Country (Fall)	
Fencing	
Field Hockey (Fall)	
Football (Fall)	
Golf (Fall)	
Gymnastics (Winter)	
Ice Hockey (Winter)	
In-Line Hockey	
Lacrosse-Boys (Spring)	
Lacrosse-Girls (Spring)	
Soccer (Fall)	
Soccer-Girls (Fall)	
Softball (Spring)	
Swimming & Diving (Winter)	
Tennis-Girls (Fall)	
Tennis-Boys (Spring)	
Track-Indoor (Winter)	
Track & Field (Spring)	
Volleyball-Girls (Fall)	
Volleyball-Boys (Spring)	
Wrestling (Winter)	
Other: Please Specify	

**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 or Scrimmages and Contests involving PIAA member schools. Such requirements 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 or Scrimmages and 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 a licensed physician of medicine or osteopathic medicine 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 or Scrimmages and 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 assume and agree to pay indebtedness or physicians' and surgeons' fees and hospital charges for such emergency medical care.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Student's Name \_\_\_\_\_ Age \_\_\_\_\_

**SECTION 3: HEALTH HISTORY**

Grade \_\_\_\_\_

Sport \_\_\_\_\_

**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 sports 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			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
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/Toes
20.	Have you ever had a stress fracture?	<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"/>
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"/>	42.	Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
				43.	Are you trying to gain or lose weight?	<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"/>
				<b>FEMALES ONLY</b>			
				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 PHYSICIAN**

Must be completed and signed by the licensed physician of medicine or osteopathic medicine performing the herein named student's comprehensive initial pre-participation physical evaluation.

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_

Enrolled in \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ )

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 Scoliosis - Grade 9		
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 and further certify that the student does not have any communicable illness or condition, which would pose a danger to teammates and/or competitors:

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) \_\_\_\_\_

Physician's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ MD or DO (circle one) 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/school/family physician, school nurse, and licensed physical therapists. Also, under the direction of a certified athletic trainer may include college/university student athletic trainers, and high school student athletic trainers.

_____ Athlete/patient signature	_____ Date	_____ UPMC Sports Medicine representative
_____ Parent / Guardian Signature	_____ Date	_____ UPMC Sports Medicine representative
_____ Signature/identify on behalf of patient/relationship	_____ Date	_____ UPMC Sports Medicine representative



**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 be provided to the family/school/team physician, school nurse, coaches, athletic directors, school principals, EMS personnel, and such persons as needed for them to provide consultation, treatment, and establish a plan of care.
- I give authorization to UPMC to use my UPMC billing information for UPMC departmental internal reporting only.
- I give authorization to UPMC (including hospitals, other entities and programs) to access medical or other information maintained on electronic information systems or stored in various forms at individual UPMC affiliates related to treatment/or services provided to me by UPMC and/or any affiliate in connection with my care, health care operations, or payment for treatment and services. I also authorize information related to my care to be provided to my family/team/school physician and such persons as necessary for them to provide consultation, treatment, and/or services to me.
- I understand that my health record(s) will not be released or obtained by UPMC unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information (Authorization)
- I understand that the release of my health record(s) will be for the purpose stated on this form.
- I understand that the health record(s) released by UPMC may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) UPMC and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- I understand that this Authorization is in effect for a period of the current scholastic sport season (fall, winter, or spring as designated by the school), or beyond in the event of the continued treatment of an injury from that designated sports season; however, no time frame specified shall go beyond one year from the date of signature.
- I understand that this Authorization is also 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.

_____ Athlete/patient signature	_____ Date	_____ UPMC Sports Medicine representative
_____ Parent / Guardian Signature	_____ Date	_____ UPMC Sports Medicine representative
_____ Signature/identify on behalf of patient/relationship	_____ Date	_____ UPMC Sports Medicine representative

