PRINT NAME ____________

GRADE FOR 2018-19 ____________

SPORTS ____________

____

____

PIAA & S.A.S.D. ATHLETIC PHYSICAL PACKET

TURN IN THE ENTIRE PACKET AT LEAST ONE WEEK PRIOR TO THE START OF THE SEASON

THE COMPLETED PACKET CAN BE SCANNED AND EMAILED TO:

athletictraining@sasd.k12.pa.us

(this email is for physical submission only)

OR

TURNED IN TO THE ATHLETIC OFFICE AT THE HIGH SCHOOL ONLY

DO NOT TURN THE FORM IN TO A COACH OR OTHER PERSON

THERE ARE TWELVE (12) PAGES IN THIS PACKET:

- Page 1: Cover Page
- Page 2: Personal and Emergency Information
- Page 3: Certification of Parent/Guardian
- Page 4: Understanding of Risk of Concussion and Traumatic Brain Injury
- Page 5: Understanding of Sudden Cardiac Arrest Symptoms and Warning Signs
- Page 6: Health History
- Page 7: PIAA Comprehensive Physical Evaluation
  (physician signature and date required after June 1st)
- Page 8: Shaler Area Policy 227.1 Acknowledgement
- Page 9: Shaler Area Student Athlete Guidelines
- Page 10: Hazing Contract
- Pages 11 & 12: UPMC Consent to Treat and HIPAA Form
  (Shaler Area contracts for athletic training services through UPMC Sports Medicine, these forms are required by the athletic training staff.)

All PARENT/GUARDIAN SIGNATURES AND THE UPMC FORMS MUST BE COMPLETED AND SIGNED BY PARENT AND ATHLETES BEFORE OBTAINING THE PHYSICAL AT SCHOOL.

PHYSICALS MUST BE CERTIFIED NO EARLIER THAN JUNE 1 TO APPLY TO THE NEXT SCHOOL YEAR. All physicals, regardless of when obtained during a school year, expire on May 31st of that school year or at the end of the last season.

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 1st and shall be effective, regardless of when performed during a school year, until the later of the next May 31st or the conclusion of the current 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

ATHLETE NAME: ______________________________ MALE____ FEMALE____

BIRTHDATE: ______________ AGE: __________ GRADE (for the seasons participating in): __________

FALL SPORT:______________ WINTER SPORT:______________ SPRING SPORT: ______________

PARENT (GUARDIAN) NAME 1: ______________________RELATIONSHIP:________________

HOME PHONE:______________ CELL PHONE:______________ WORK PHONE:______________

PARENT (GUARDIAN) NAME 2: ______________________RELATIONSHIP:________________

HOME PHONE:______________ CELL PHONE:______________ WORK PHONE:______________

ATHLETE ADDRESS:______________________ CITY:______________ ZIP: __________

EMERGENCY CONTACT IN THE EVENT PARENTS/GUARDIANS CAN NOT BE CONTACTED:

NAME: ______________________ RELATIONSHIP TO ATHLETE: ________________

HOME PHONE:______________ CELL PHONE:______________ WORK PHONE:______________

ATHLETE'S PHYSICIAN NAME: ______________________ TELEPHONE: ______________

ATHLETE'S ALLERGIES: ____

____

ATHLETE'S HEALTH CONDITIONS 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, 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.

______________________________	______________________________	Date___/___/____
Signature of Student-Athlete	Print Student-Athlete's Name	
______________________________	______________________________	Date___/___/____
Signature of Parent/Guardian	Print Parent/Guardian's Name	

Student's Name ______________________________ Age________ Grade________

SECTION 5: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

#	Question	Yes	No
1.	Has a doctor ever denied or restricted your participation in sport(s) for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like asthma or diabetes)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8.	Does your heart race or skip beats during exercise?	☐	☐
9.	Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection		
10.	Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	☐	☐
11.	Has anyone in your family died for no apparent reason?	☐	☐
12.	Does anyone in your family have a heart problem?	☐	☐
13.	Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	☐	☐
14.	Does anyone in your family have Marfan syndrome?	☐	☐
15.	Have you ever spent the night in a hospital?	☐	☐
16.	Have you ever had surgery?	☐	☐
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:	☐	☐
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
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:	☐	☐

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes

#	Question	Yes	No
20.	Have you ever had a stress fracture?	☐	☐
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22.	Do you regularly use a brace or assistive device?	☐	☐
23.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
24.	Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐
25.	Is there anyone in your family who has asthma?	☐	☐
26.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
27.	Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30.	Have you ever had a herpes skin infection?	☐	☐
	CONCUSSION OR TRAUMATIC BRAIN INJURY		
31.	Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
32.	Have you been hit in the head and been confused or lost your memory?	☐	☐
33.	Do you experience dizziness and/or headaches with exercise?	☐	☐
34.	Have you ever had a seizure?	☐	☐
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39.	Have you had any problems with your eyes or vision?	☐	☐
40.	Do you wear glasses or contact lenses?	☐	☐
41.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42.	Are you unhappy with your weight?	☐	☐
43.	Are you trying to gain or lose weight?	☐	☐
44.	Has anyone recommended you change your weight or eating habits?	☐	☐
45.	Do you limit or carefully control what you eat?	☐	☐
46.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
	FEMALES ONLY	☐	☐
47.	Have you ever had a menstrual period?	☐	☐
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?	☐	☐

#'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		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ 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 ___/___/___

SHALER AREA SCHOOL DISTRICT
ACTIVITIES / ATHLETIC DEPARTMENTS
(412) 492 - 1200 ext. 1550 - Athletics
(412) 492 - 1200 ext. 1530 - Activities

Parent / Student Acknowledgement of Policy 227.1

TO: PARENTS AND GUARDIANS

School activities are an important part of your school life. It is through involvement in activities that you are able to learn more about the workings of the school, go deeper into one particular field of interest, promote your own social life through associations with others and also have a good deal of fun. Participation in extracurricular activities is a privilege and also carries with it certain responsibilities as the school and community are being represented.

The student must follow academic eligibility policies as well as attendance and behavior regulations. Students who are absent on the day of the activity or club in which they are involved **cannot** participate in that event. This includes sports, school plays, musical, talent show, dances, band and band fronts, cheerleaders, etc.

The Shaler Area School District, recognizing the growing problem of drug and alcohol abuse among teens, has revised the drug and alcohol policy (Board Policy 227.1) that will pertain to all athletes and participants in any extracurricular activity as of February, 2001. Along with the above policies, participation will also be determined by compliance with Board Policy 227.1. *Compliance with this policy is mandatory in order for the student to participate in any extracurricular activity.

Please read, sign and return the bottom portion of this letter to the athletic office or activity sponsor/coach along with the physical and emergency cards if applicable. Participation in sports or seasonal-type activities cannot commence until this form is signed by both the student and the parent/guardian. This form shall be in effect for a period of twelve (12) months and shall cover participation in any sport or seasonal activity in which the student may participate during that twelve (12) month period.

———————— **Sign and Return** ————————

I have read the provisions of the Shaler Area School District's Policy 227.1, Drug and Alcohol Awareness for Seasonal Extracurricular Activities and Athletic Programs, as it pertains to participation in athletics and activities. I agree to comply with the rules and am aware of the consequences involved in the violation of this policy.

Print Student Name ______________________________

Student Signature ____________________ Date ______________

Parent Signature ____________________ Date ______________

SHALER AREA SCHOOL DISTRICT
ATHLETIC DEPARTMENT
STUDENT-ATHLETE GUIDELINES
SCHOLASTIC ELIGIBILITY-TRAINING RULES- COACH'S PEROGATIVE- EQUIPMENT ISSUE- AGREEMENT

The following are procedures and regulations relative to participation in the Shaler Area School District Athletic Program. Failure on the part of the student athletes to adhere to these procedures and regulations may subject the student athlete to probation, suspension, or dismissal from the activity in which they are participating.

STUDENT-ATHLETE GUIDELINES:

1. A student athlete's citizenship and conduct must be exemplary at all times. The conduct of a student athlete must be a positive reflection and representation of the Shaler Area School district.
2. A student athlete must at all times display a positive attitude toward the activity, toward his/her teammates, and toward the coach. Discourteous or inappropriate behavior will not be tolerated. The team and its success shall have preference over personal wishes and desires at all times.
3. Practice meetings, event attendance:
   a. A student athlete shall attend all team functions (practices, meetings, and events) unless ill/injured and emergency situation develops, or a coach or doctor excuses a student. On non-school days, coaches must receive notice of the necessity that a student misses a practice, meeting, or event before the practice, meeting, or event is scheduled to begin.
   b. A student athlete shall not be permitted to practice or participate in any competition during an "out of school" or "in school" suspension. In cases of discipline, students are obligated to meet their detention or disciplinary responsibilities prior to attending practices / events.
   c. Except in cases of emergency, any team function missed without proper notification and/ or excused by the coach may result in probation, suspension or dismissal from the team.
   d. Doctor, dentist and other similar appointments should be made during a time which will not interfere with the student's participation in a team function.
   e. A student athlete must be in attendance at school on the day of an event (except Saturday) by 10:00 am in order to be eligible to participate in an event. Note: Saturday contests require Friday attendance.
4. A student athlete who is dismissed from a team for disciplinary reasons by the coach will not be eligible to participate on another team during the same season.

SCHOLASTIC ELIGIBILITY:
Determined in accordance with both PIAA eligibility requirements as well as current Shaler Area School District Policy relating to athletic eligibility requirements (refer to athletic handbook).

TRAINING RULES:
Student athletes must abstain from the possession of or use of cigarettes, cigars, chewing tobacco, alcoholic beverages, and non-prescribed drugs at all times. Failure to comply will result in suspension or dismissal from the team in accordance with the Shaler Area School District's Drug & Alcohol Policy for Extra-Curricular Activities and Athletics.

COACHING PREROGATIVE:
Subject to the Shaler Area School District policies and procedures, school regulations, and state and federal law. The coach is the decision-maker with regard to the following items:

1. Selection, placement and play of student-athletes.
2. Practice times, dates and procedures.
3. Establishment and enforcement of all guidelines and training rules related to an activity.
4. Event strategies.
5. Varsity letter awards.

EQUIPMENT ISSUE:
Each student athlete must return all issued equipment within two (2) days of the last game or practice of the season. The student athlete must pay for lost or stolen equipment or he/she will not be permitted to participate in any additional athletic activity. Stealing, possessing or wearing stolen equipment from a Shaler Area athletic activity will be cause for suspension or dismissal.

AGREEMENT:
We, the undersigned, have read the above procedures and regulations and do hereby agree to the terms as stated. Furthermore, we agree to first contact the "Coach-In-Charge" pertaining to any preblem(s) dealing with player/team personnel in accordance with school policy. If necessary, a meeting will then be scheduled between the undersigned, the coach, and the Director of Athletics.

PRINT ATHLETE NAME HERE ______________________________

ATHLETE SIGNATURE______________________________ **DATE**____________

PARENT/GUARDIAN SIGNATURE______________________________ **DATE**____________

Once signed and returned, a copy of this document will be forwarded for your records. Failure to sign will eliminate your child from participation.

ANTI-HAZING CONTRACT

In accordance with the Shaler Area School District Policies hazing is not permitted. All acts of hazing by any organization, member, and/or alumni are specifically forbidden.

> **Hazing is:** Any action taken or situation created intentionally whether on or off campus, to produce mental, emotional, or physical discomfort, embarrassment, harassment, or ridicule. Such activities and situations may include, but are not limited to the following: use of alcohol; paddling in any form; creation of excessive fatigue; quests; treasure hunts, scavenger hunts; physical and psychological shocks; inappropriate activities, wearing publicly any apparel which is conspicuous and not normally in good taste; engaging in public stunts and buffoonery; morally degrading or humiliating games and activities; and/or any other activities that are not consistent with academic achievement, or that otherwise compromise the dignity of the individual including forced use and abuse of alcohol and drugs. Any activity where a single group of individuals are isolated for an activity beyond the normal scope of actions.

Students, who believe that the behavior of other student-athletes or staff is questionable, should bring the matter to a coach, the Athletic Director, or Principal. It is an obligation of all student-athletes to address inappropriate behavior or actions.

I fully understand the Shaler Area's policy towards hazing and initiation activity. I will not engage in any hazing or initiation activity. I further agree to provide an environment that is free from harassment of any kind.

________________________________ ________________________________

Student Signature **Date:** ________ Parent Signature **Date:** ______

Printed Name:__________________________**SPORT:**_________________________

As part of a contractual agreement with UPMC Sports Medicine, certified athletic trainers may aide in the prevention, recognition, evaluation, and treatment of athletic injuries. **Please note that the forms below have no relationship to your health insurance plan and in no way, influence your choice of medical care.** UPMC must have these forms completed to comply with privacy and standard consent to treat laws.

(1) UPMC Authorization for Release of Protected Health Information

- I authorize UPMC to provide information related to the athlete's care to family/school/team physicians, school nurses, coaches, athletic directors, school principals, EMS personnel, and such other persons as is necessary 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 use the athlete's medical information for UPMC internal departmental reporting 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 about the athlete's 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 because 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 the athlete is 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 at the location 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.

(Continued other side)

(2) UPMC Consent for Treatment and Healthcare Operations

I 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 athletic training students and high school student aides may also provide care.

I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

In the event of ImPACT baseline testing, I understand the ImPACT baseline testing provided by UPMC Sports Medicine is not intended to prevent, diagnose, or treat a concussion and is not to be administered following a possible concussion. If the athlete suffers a concussion, the administration of an ImPACT post-test is generally conducted at the discretion of the concussion specialist at their facility.

(3) UPMC Privacy Practices

I understand that copies of the UPMC Notice of Privacy Practices document are available at the school, can be sent in the mail upon my request or viewed at http://www.upmc.com/patients-visitors/privacy-info/Pages/default.aspx. I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy Practices.

By signing below, I am acknowledging the above (1) Authorization for Release of Protected Health Information, (2) Consent for Treatment and Healthcare Operations, and (3) Notice of Privacy Practices.

_________________________________ ______________
Athlete signature Date

_________________________________ ______________
Parent or guardian signature/relationship Date

_________________________________ ______________
Parent or guardian signature/relationship Date

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:

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