Tulpehocken Area School District Athletic Enrollment Information Form

Please type or complete in Blue or Black ink

Student's Name ____

Grad Year ______________ **Student's Birthdate** _______________________ **Student's Age** ___________

Preferred email for future PIAA Paperwork Info from the Athletic Office and schedule info from coaches:

Family Email(s) ____

2019 – 2020 Sports

Please list what sports you will play during the 2019 – 2020 school year and check what grade(s) you have previously played that sport.

	Check the grade(s) you have previously played
Fall Sport ________________________________	**7** ☐ **8** ☐ **9** ☐ **10** ☐ **11** ☐
Winter Sport ______________________________	**7** ☐ **8** ☐ **9** ☐ **10** ☐ **11** ☐
Spring Sport _______________________________	**7** ☐ **8** ☐ **9** ☐ **10** ☐ **11** ☐

Enrollment Information – Please Complete Entirely and Sign Below

What grade did you enroll (start) at Tulpehocken? ____________________

Have you ever attended another school district other than Tulpehocken? Yes ☐ No ☐ *(Check One)*

If yes, what school district(s) did you attend? ____

What Grade(s) were you there? ____

List any sport(s) you played there AFTER 6th Grade: ____

What school district did you last play for: ____

Have you repeated a grade AFTER 6th grade? Yes ☐ No ☐ *(Check One)*

If yes, what grade did you repeat? _____________

Please *Check if Applicable:*

Homeschooled ☐ **Cyber Schooled** ☐

Cyber School Program: ____________________________________

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** ____________

Tulpehocken Area School District

Informed Consent for Athletic Participation

To Athletes and their parents of the Tulpehocken Area School District,

We are pleased that your child will be a participant in interscholastic athletics at Tulpehocken. Athletes throughout the years have benefited from programs such as ours. We hope your child's participation will provide him/her with rewarding experiences. We are, as we must be, concerned with the safety and protection of your child. It is with this in mind that we send this letter to you.

First, it is to advise you of the possibility of bodily injury involved in interscholastic athletic play. When your child chooses to participate in athletics and you give your permission, assumption of these risks must be made. The athletic staff wishes to advise you that possible injury could range from minor aches and pains up to and including catastrophic injury or even death. Parents /Guardians are financially responsible for any medical bills incurred during athletic participation.

Second, we strongly urge that you purchase the Student Accident Insurance or present evidence of other satisfactory coverage. So that we can be aware of your child's insurance coverage, please complete the portion concerning this on Section 1 of the PIAA form. Parents / Guardians must inform the athletic department of any changes to insurance coverage.

Third, it must be understood that all student athletes shall abide by all rules, regulations, and information described in the discipline code and co-curricular guidelines.

If you have any questions, please feel free to contact the Athletic Director at 610-488-6286.

Your signatures below indicate that you have fully read, understand and acknowledge all of the information in this letter concerning (a) the element of risk involved in athletics, (b) that your child has the proper insurance coverage, and (c) that you fully agree to abide by all of the districts rules and regulations as described above.

Emergency Medical Authorization

Purpose: To enable parents/guardians to authorize the provision of emergency treatment for athletes who become ill or injured under school authority when the parent/guardian cannot be reached.

Consent

We/I give consent for the school's licensed athletic trainers and physicians assigned by St. Luke's University Health Network, to evaluate athletic injuries/illnesses on site or during Athletic Training room hours.

In the event that reasonable attempts to contact me or my emergency contact at the phone numbers listed on the PIAA Section 1 form have been unsuccessful, I hereby give my consent for the school district to obtain and grant permission for the emergency treatment for my son/daughter by a licensed physician/dentist.

This authorization does not cover major surgery unless the medical options of two other licensed physicians/dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medication being taken and any physical impairments: ____
____

____________________________________ ____________________________

Name of Parent/Guardian (Please Print) Date

____

Signature of Parent/Guardian

Student's Name:__________________________ **Date of Birth:** ________________ **Grad Year:** ____________

SECTION 5: HEALTH HISTORY – Please type or complete in Blue or Black Ink

YES NO (please check one) ***PLEASE EXPLAIN (AGE / DATE IF APPLICABLE) ALL YES ANSWERS IN SPACE PROVIDED***

1) ☐Y ☐N Has a doctor ever denied or restricted your participation in sport(s) for any reason? ________________

2) ☐Y ☐N Do you have an ongoing medical condition (like asthma or diabetes)? ________________

3) ☐Y ☐N Are you currently taking any medications (prescription or over-the-counter)? ________________

4) ☐Y ☐N Do you have allergies to medicines, pollens, foods, or stinging insects? ________________

5) ☐Y ☐N Have you ever passed out or nearly passed out DURING exercise? ________________
6) ☐Y ☐N Have you ever passed out or nearly passed out AFTER exercise? ________________
7) ☐Y ☐N Have you ever had discomfort, pain, or pressure in your chest during exercise? ________________
8) ☐Y ☐N Does your heart race or skip beats during exercise? ________________
9) ☐Y ☐N Has a doctor ever told you that you have (check all that apply and explain below):
☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection

10) ☐Y ☐N Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) ________________

11) ☐Y ☐N Has anyone in your family died for no apparent reason? ________________
12) ☐Y ☐N Does anyone in your family have a heart problem? ________________
13) ☐Y ☐N Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50? ________________
14) ☐Y ☐N Does anyone in your family have Marfan syndrome? ________________
15) ☐Y ☐N Have you ever spent the night in a hospital? ________________
16) ☐Y ☐N Have you ever had surgery? ________________
17) ☐Y ☐N 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, please explain below by the body part.
18) ☐Y ☐N Have you had any broken or fractured bones or dislocated joints? If Yes, please explain below by the body part.
19) ☐Y ☐N 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, please explain below by the body part.

Neck		Chest/Ribs	
Face		Back	
Shoulder		Hip	
Upper Arm		Thigh	
Elbow		Knee	
Forearm		Shin/Calf	
Wrist		Ankle	
Hand		Foot	
Fingers		Toes	

20) ☐Y ☐N Have you ever had a stress (overuse) fracture? ________________
21) ☐Y ☐N Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? ________________
22) ☐Y ☐N Do you regularly use a brace or get taped? ________________
23) ☐Y ☐N Has a doctor ever told you that you have asthma or allergies? ________________
24) ☐Y ☐N Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? ________________

25) ☐Y ☐N Is there anyone in your family who has asthma? ________________
26) ☐Y ☐N Have you ever used an inhaler or taken asthma medicine? ________________
27) ☐Y ☐N Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? ________________

28) ☐Y ☐N Have you ever had infectious mononucleosis (mono)? ________________
29) ☐Y ☐N Do you have any rashes, pressure sores, or other skin problems? ________________
30) ☐Y ☐N Have you ever had a herpes skin infection? ________________

CONCUSSION OR TRAUMATIC BRAIN INJURY – Please also complete the concussion management section on the next page.

31) ☐Y ☐N Have you ever had a concussion or traumatic brain injury? ________________
32) ☐Y ☐N Have you been hit in the head and been confused or lost your memory? ________________
33) ☐Y ☐N Do you experience dizziness and/or headaches with exercise? ________________

34) ☐Y ☐N Have you ever had a seizure? ________________
35) ☐Y ☐N Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ________________
36) ☐Y ☐N Have you ever been unable to move your arms or legs after being hit or falling? ________________

Student's Name:_______________________________ **Date of Birth:** ____________________ **Grad Year:** ______________

SECTION 5: HEALTH HISTORY (CONTINUED) – Please type or complete in Blue or Black Ink

YES NO (please check one) *PLEASE EXPLAIN (AGE / DATE IF APPLICABLE) ALL YES ANSWERS IN SPACE PROVIDED*

37) ☐Y ☐N When exercising in the heat, do you have severe muscle cramps or become ill? ____________________
38) ☐Y ☐N Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ____________________
____
39) ☐Y ☐N Have you had any problems with your eyes or vision? ____________________
40) ☐Y ☐N Do you wear glasses or contact lenses? ____________________
41) ☐Y ☐N Do you wear protective eyewear such as goggles or a face shield? ____________________
42) ☐Y ☐N Are you unhappy with your weight? ____________________
43) ☐Y ☐N Are you trying to gain or lose weight? ____________________
44) ☐Y ☐N Has anyone recommended you change your weight or eating habits? ____________________
45) ☐Y ☐N Do you limit or carefully control what you eat? ____________________
46) ☐Y ☐N Do you have any concerns that you would like to discuss with a doctor? ____________________

FEMALES ONLY

47) ☐Y ☐N 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) ☐Y ☐N Are you pregnant?

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**____________

Concussion History and Concussion Management Consent Form
(ALL athletes MUST complete)

Have you ever been diagnosed wth migraines? ☐ **Yes** ☐ **No** **(Check One)**

Have you ever been diagnosed with a concussion? ☐ **Yes** ☐ **No** **(Check One)**

If yes, please list the date(s) of your concussion(s): ____

______ Total number of concussions that have resulted in loss of consciousness (blacked out)

______ Total number of concussions that resulted in confusion

______ Total number of concussions that resulted in difficulty remembering events that occurred immediately after injury

______ Total number of concussions that resulted in difficulty remembering events that occurred immediately before injury

How long (approx.) did it take you to recover from EACH concussion? ____
____

Consent for Concussion Management

I hereby give my permission for (name of student athlete) ______________________________ to participate in the Concussion Management Program. This program may include taking a baseline neurocognitive exam prior to their athletic season. I understand that if my child suffers a suspected head injury or concussion, they will be required to see a licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management. If diagnosed with a concussion, they may be required to take a post-injury neurocognitive exam. Their symptoms may be monitored by completing daily graded symptom charts. Once cleared by their physician, they will be required to complete a step-by-step gradual progression back to physical activity and sport.

Tulpehocken Area School District may release the neurocognitive results to my child's primary care physician, neurologist, or other treating physician.

Doctor or Practice: ______________________________ **Phone Number:** ______________________

I understand that general information about my child's concussion may be provided to my child's school nurse, guidance counselor, and teachers, for the purposes of providing temporary academic modifications, if necessary.

Name of parent or guardian (Please Print): ______________________________

Signature of parent or guardian: ______________________________

Date: ______________________

SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER (NOT VALID UNLESS DATED BY MEDICAL EXAMINER ON OR AFTER JUNE 1, 2019)

PLEASE COMPLETE IN INK PRIOR TO PHYSICAL

Student's Name ____ Age_____________ Grad Year______________

Enrolled in **Tulpehocken Jr / Sr High** School Sports to be played____

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 into the Principal, or the Principal's designee, of the student's school.

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 ____

Recommendations(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 _____/_____/_____

NOT VALID UNLESS DATED BY AUTHORIZED MEDICAL EXAMINER ON OR AFTER JUNE 1, 2019