



BETHLEHEM
AREA SCHOOL DISTRICT



Arbiter Registration Instructions

Information Needed to Register

- Images of PIAA Sections 5 and 6, and ImPact conformation page
- Parent/Guardian Information
- Student Information
- Emergency Contact Information
- Doctor and Insurance Information

To register: A parent/guardian, along with the student-athlete, should register on Arbiter.

1. Use the following link, [Arbiter Registration](#), or go to the website hello.students.arbitersports.com and click "Get Started or Sign In".
2. Create your secure Arbiter Registration account by entering the account owner's first and last names (parent/guardian), e-mail address and password; select "I Agree to the ArbiterSports Terms of Service"; select "Create Account".
3. You will receive an email with a link to activate your new account. If you don't see the email, check your other e-mail folders (spam, junk, etc.).
4. Click on the link in your e-mail, which will log you into Arbiter Registration.
5. On the dashboard, you will search "Freedom High School" or "Liberty High School" (or respective MS) to register.
6. Once you are on the registration form, complete the information requested. All fields with a red* are required to have an answer.
7. Click "Save & Continue" when your form is complete. *Make sure to respond to the recruiting ad or it will not process your submission .*
8. Review your registration summary.
9. Click the blue "Submit" button on the right side of the page. After selecting "Submit" the registration will be complete. You will receive a completion email from Arbiter Registration confirming your registration. *This does not mean your child is cleared to play yet; it just tells you the form has been submitted.*

At any time, you may log into Arbiter Registration to update your information and to check your registration(s)/sign ups. To view a completed registration, select the "Registration" tab on the blue bar.

Support: If you need assistance with registration, contact ArbiterSports at support@arbitersports.com or 1-800-311-4060. Support is available 7 days a week and messages will be returned promptly.

Physical Dates and Details

- Freedom: May 27th, 5-7:45 p.m. in the main gym
- Please make your appointment using this link for the Freedom HS Physicals [https://www.signupgenius.com/go/10C0E49ADAE28A0F5C07-63503905-basd#/#](https://www.signupgenius.com/go/10C0E49ADAE28A0F5C07-63503905-basd#/)
- Liberty: June 2nd, 5-7:45 p.m. in the auxiliary gym
- Please make your appointment using this link for the Liberty HS Physicals [https://www.signupgenius.com/go/70A0944AAA92FA7FA7-63707292-basd#/#](https://www.signupgenius.com/go/70A0944AAA92FA7FA7-63707292-basd#/)

SECTION 5: HEALTH HISTORY

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

<p>1. Has a doctor ever denied or restricted your participation in sport(s) for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you have an ongoing medical condition (like asthma or diabetes)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Has a doctor ever told you that you have (check all that apply):</p> <p><input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection</p> <p>10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Does anyone in your family have a heart problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Does anyone in your family have Marfan Syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever spent the night in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; padding: 5px;"> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, circle affected area below:</p> <p>18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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"/> Yes <input type="checkbox"/> No</p> </div> <table border="0" style="width: 100%; font-size: small;"> <tr> <td>Head</td><td>Neck</td><td>Shoulder</td><td>Upper arm</td><td>Elbow</td><td>Forearm</td><td>Hand/ Fingers</td><td>Chest</td></tr> <tr> <td>Upper back</td><td>Lower back</td><td>Hip</td><td>Thigh</td><td>Knee</td><td>Calf/shin</td><td>Ankle</td><td>Foot/ Toes</td></tr> </table> <p>20. Have you ever had a stress fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Do you regularly use a brace or assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest	Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes	<p>23. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Is there anyone in your family who has asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Have you ever had a herpes skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; padding: 5px;"> <p>CONCUSSION OR TRAUMATIC BRAIN INJURY</p> <p>31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Do you experience dizziness and/or headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </div> <p>34. Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Are you unhappy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>MENSTRUAL QUESTIONS- IF APPLICABLE <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. How old were you when you had your first menstrual period? _____</p> <p>49. How many periods have you had in the last 12 months? _____</p> <p>50. When was your last menstrual period? _____</p>
Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest										
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes										

#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 ____ for 20____ - 20____
School Year

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		<input type="checkbox"/> Heart murmur <input type="checkbox"/> Femoral pulses to exclude aortic coarctation <input type="checkbox"/> 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 ____/____/____