



**ATTENTION:** Parents/Guardians and Student-Athletes

**SUBJECT:** 2018-2019 PIAA Pre-Participation Physical Packet  
**PHYSICAL MUST OCCUR ON OR AFTER JUNE 1, 2018**

- Sports physicals are offered at both high schools at the start of each season. Please check with the Athletic Office or coach for the scheduled dates.  
(SECTIONS 1-5 SHOULD BE COMPLETED AND BROUGHT WITH YOU TO THE PHYSICAL)

**Physical Dates and details:**

- Friday, June 1, 2018 from 3:00 pm – 5:30 pm. (In the Liberty High School Memorial gym)
  - Tuesday, June 5, 2018 from 5:00 pm – 7:30 pm. (In the Freedom High School Main Gym)
  - COST: FREE
- Sections 1 – 5 of the PIAA physical form MUST be completed and signed by a parent/guardian.
  - Section 6 must be completed and signed by an Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE).

Once all forms are completed, return the packet to:

High School Student Participants: **Athletic Trainers at Liberty High School**  
Middle School Participants: **Return to respective middle school Athletic Coordinators.**

**All physical packets must be completed and turned into the Athletic Trainers on or before Friday, August 3, 2018. Athletic packets will not be processed from June 18 – August 3, 2018. Should you have any questions, please contact the *Liberty High School athletic office at the number below.***

Liberty Athletic Office: Mrs. Maria Guzman 610-691-7200 Ext: 50951

Freedom Athletic Office: 610-867-5843 Ext. 53950

# BASD SCHOOLS

## Athletic Physical Packet

### ATTENTION: Parents/Guardians and Student-Athletes

Attached is the necessary paperwork required to participate in athletics.

All forms must be 100% complete, signed and returned as a packet BEFORE you will be allowed to participate in your respective sport(s).

- ❖ Athlete Information (see below)
- ❖ BASD Policy letter-acknowledgement form (see below)

NOTE: Copy of policy is attached. KEEP policy packet and return form.

- ❖ PIAA Pre-Participation Physical Forms (attached)

**PHYSICALS MUST OCCUR ON OR AFTER JUNE 1, of the school year of participation**

**Please review Physical Form information on the front cover of this packet**

Once all forms are completed, return the completed packet to the Athletic office at the student's respective High School or to the main office at the Middle Schools.

Liberty Athletic Office - 610-691-7200, ext. 50951 / Freedom Athletic Office - 610-867-5843, ext. 53951

### BETHLEHEM AREA SCHOOL DISTRICT

#### ATHLETE'S INFORMATION:

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Graduation Year: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Student ID: \_\_\_\_\_

Current grade: \_\_\_\_\_ (grade entering) Student Email: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian Telephone #1 : \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Telephone #1 : \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_

School Attending: \_\_\_\_\_ City & State of Birth: \_\_\_\_\_  
(include charter, cyber, homeschool etc.)

Sport(s) trying out for: \_\_\_\_\_

#### BASD Policy Letter - Acknowledgement Form

My Signature acknowledges that I have read, understand and will abide by the Bethlehem Area School District's athletic policy.

\_\_\_\_\_

Date

\_\_\_\_\_

Parent/Guardian - Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Student Athlete - Signature

04-2016ljws



**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 1<sup>st</sup> and shall be effective, regardless of when performed during a school year, until the latter of the next May 31<sup>st</sup> or the conclusion of the 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**

Student's Name \_\_\_\_\_ Male/Female (circle one)

Date of Student's Birth: \_\_\_/\_\_\_/\_\_\_\_\_ Age of Student on Last Birthday: \_\_\_ Grade for Current School Year: \_\_\_

Current Physical Address \_\_\_\_\_

Current Home Phone # ( ) \_\_\_\_\_ Parent/Guardian Current Cellular Phone # ( ) \_\_\_\_\_

Fall Sport(s): \_\_\_\_\_ Winter Sport(s): \_\_\_\_\_ Spring Sport(s): \_\_\_\_\_

**EMERGENCY INFORMATION**

Parent's/Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Emergency Contact Telephone # ( ) \_\_\_\_\_

Secondary Emergency Contact Person's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Emergency Contact Telephone # ( ) \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

Address \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_

Family Physician's Name \_\_\_\_\_, MD or DO (circle one)

Address \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_

Student's Allergies \_\_\_\_\_

Student's Health Condition(s) 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](http://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.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Print Student-Athlete's Name

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Print Parent/Guardian's Name

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION 5: HEALTH HISTORY**

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

- |                                                                                                                                                                                   |                          |                          |           |       |           |               |            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|-----------|-------|-----------|---------------|------------|
|                                                                                                                                                                                   | Yes                      | No                       |           |       |           |               |            |
| 1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |           |       |           |               |            |
| 2. Do you have an ongoing medical condition (like asthma or diabetes)?                                                                                                            | <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"/> |           |       |           |               |            |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |           |       |           |               |            |
| 5. Have you ever passed out or nearly passed out DURING exercise?                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |           |       |           |               |            |
| 6. Have you ever passed out or nearly passed out AFTER exercise?                                                                                                                  | <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"/> |           |       |           |               |            |
| 8. Does your heart race or skip beats during exercise?                                                                                                                            | <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"/> | <input type="checkbox"/> |           |       |           |               |            |
| <input type="checkbox"/> High cholesterol                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |           |       |           |               |            |
| <input type="checkbox"/> Heart murmur                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |           |       |           |               |            |
| <input type="checkbox"/> Heart 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"/> |           |       |           |               |            |
| 11. Has anyone in your family died for no apparent reason?                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |           |       |           |               |            |
| 12. Does anyone in your family have a heart problem?                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |           |       |           |               |            |
| 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"/> | <input type="checkbox"/> |           |       |           |               |            |
| 14. Does anyone in your family have Marfan syndrome?                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |           |       |           |               |            |
| 15. Have you ever spent the night in a hospital?                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |           |       |           |               |            |
| 16. Have you ever had surgery?                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |           |       |           |               |            |
| 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:      | <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"/> |           |       |           |               |            |
| 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"/> |           |       |           |               |            |
| 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"/> |           |       |           |               |            |
| 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"/> |           |       |           |               |            |
| 22. Do you regularly use a brace or assistive device?                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |           |       |           |               |            |

- |                                                                                                            |                          |                          |
|------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
|                                                                                                            | Yes                      | No                       |
| 23. Has a doctor ever told you that you have asthma or allergies?                                          | <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"/> |
| 25. Is there anyone in your family who has asthma?                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine?                                                | <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"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems?                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you ever had a herpes skin infection?                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>CONCUSSION OR TRAUMATIC BRAIN INJURY</b>                                                                |                          |                          |
| 31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?            | <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"/> |
| 33. Do you experience dizziness and/or headaches with exercise?                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever had a seizure?                                                                           | <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"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling?                        | <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"/> |
| 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"/> |
| 39. Have you had any problems with your eyes or vision?                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses?                                                                 | <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"/> |
| 42. Are you unhappy 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"/> |

Explain "Yes" answers here:

#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		<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 \_\_\_\_/\_\_\_\_/\_\_\_\_





## Consent to Treat Patient

*St. Luke's University Health Network: Sports Medicine Relationships*

### CONSENT TO TREAT:

I am the parent/legal guardian of the child named below and have the legal right to consent to permit St. Luke's University Health Network and its personnel to deliver health care and treatment to my child at \_\_\_\_\_ ("Program") practices and games by its athletic trainers, physical therapists and physicians. Such health care and treatment may include medical evaluation of injuries, administration of first aid for athletic injuries, and providing initial treatment and management of injuries, as may be deemed necessary or advisable by St. Luke's personnel in the treatment and diagnosis of my child. I understand that this consent will remain in effect until my child ceases to be a member of the Program or until this consent is revoked by me by sending a written notification to St. Luke's, 1441 Schoenersville Road, Bethlehem, PA 18018, Attention: Senior Director, Sports Medicine Relationships.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### LIMITATIONS:

Identify any specific limitations or exclusions for which this consent is given. (If none, state "none".)

\_\_\_\_\_

Parent/Legal Guardian Name (print) \_\_\_\_\_

Relationship: \_\_\_\_\_

Parent/Legal Guardian Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Legal Guardian Emergency Contact Number (First): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Parent/Legal Guardian Emergency Contact Number (Second): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

St. Luke's University Health Network  
HIPAA Privacy Authorization Form  
Sports Medicine

**Authorization for Use or Disclosure of Protected Health Information**

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization to Disclose.** I authorize St. Luke's University Health Network and its affiliates ("St. Luke's") to use and disclose to \_\_\_\_\_, health information about my child obtained by St. Luke's in providing health services to my child during participation in practices and games. The purposes of such uses and disclosures may include communicating with the Program's coaches and team/organization administrative staff, athletic trainers, school nurse, guidance counselor and other individuals that are affiliated with the Program about my child's: (i) prognosis and recommended activities following an injury; (ii) ability to participate in training, practices, games, and other team activities; and (iii) other matters related to my child's activities with the Program.

I understand and authorize the release of medical records, including all diagnostic images and other medical reports, except as noted below:

**EXCEPTION: I do not give permission to release (please specify):**

\_\_\_\_\_

2. **Refusal to Sign.** I understand that I may refuse to sign this authorization. St. Luke's may not refuse to treat my child based on my refusal to sign this Authorization.
3. **Expiration of Authorization.** This Authorization shall be in force and effect for a period of one year from the date this form is signed, at which time this Authorization expires. Once this Authorization has expired, St. Luke's may no longer use or disclose my child's health information for the purposes listed in this Authorization unless I sign a new Authorization. However, materials that were created prior to the expiration of this Authorization may continue to be used or disclosed for the purposes listed in this Authorization.
4. **Revocation of Authorization.** I understand that I may revoke this authorization at any time, in writing, except to the extent that St. Luke's has already relied on it in making a disclosure. If I wish to revoke this Authorization, I will send a written request to: St. Luke's, 1441 Schoenersville Road, Bethlehem, PA. 18018, Attention: Senior Director, Sports Medicine Relationships.
5. **Further Disclosure.** I understand that information used or disclosed pursuant to this Authorization may be further reproduced, copied or disclosed by those who receive or view the information, and the laws governing patient privacy may no longer protect the information.

X \_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of parent or guardian and  
His/her relationship to child

\_\_\_\_\_  
Child's name



Dear Parent/Guardian and Student Athlete:

Welcome to the Interscholastic Athletic Program offered in the Bethlehem Area School District. This letter includes various information and policies associated with your child's participation in the Bethlehem Area School District's athletic program. It is very important information, **PLEASE READ IT CAREFULLY AND SAVE FOR LATER REFERENCE.**

**BE SURE THAT YOU AND YOUR CHILD READ THIS LETTER, SIGN THE ATTACHED FORM, AND RETURN IT AS SOON AS POSSIBLE WITH HIS/HER PHYSICAL PAPERS PRIOR TO THE FIRST PRACTICE OF THE SPORT IN WHICH THEY WISH TO PARTICIPATE.**

### **BETHLEHEM AREA SCHOOL DISTRICT'S ATHLETIC POLICY**

#### **I. MISSION STATEMENT**

The purpose of interscholastic athletics in the Bethlehem Area School District is to provide a wide variety of competitive athletic experiences to student athletes in a way that complements the academic experience of both the participant and the student body in general, and that instills, develops, and encourages the positive characteristics of excellence, sportsmanship, fitness, teamwork and discipline.

#### **II. INTRODUCTION AND GOALS**

The athletic program is an important and integral part of the total school program and is open to participation by all students regardless of individual differences. Through voluntary participation, the athlete gives time, energy, and loyalty to the program. He/she also accepts the training rules, regulations, and responsibilities which are unique to an athletic program. In order to contribute to the welfare of the group, the athlete must willingly assume these obligations even to the extent that he/she may be required to make sacrifices not required of others.

#### **Goals of the Department of Athletics—**

1. To provide a wide variety of competitive athletic experiences in programs that encourage broad participation by girls and boys.

following Sunday through the Saturday immediately following the next Friday as of which you meet this requirement. Additionally, a student athlete may not be failing more than one course during a grading period.

- b. Any conviction resulting from a civil law infraction or other conduct by a student athlete occurring during that season that is determined by the head coach and school administration to be detrimental to the athletic program, school, or school district, will result in counseling by the head coach and a school administrator with possible suspension from team.
- c. No athlete may quit one sport and report for another after a season has begun without the mutual consent of both coaches and the administration. ("Season" is defined as that time from the first formal practice to the last contest, including tournaments.)
- d. Athletes must travel to and from contests, away from the Bethlehem Area School District in transportation provided by the District. The only exceptions are:
  - 1. Injury to a participant which would require alternate transportation.
  - 2. Prior arrangements made in writing between the participant's parent/guardian and the coach for the student to ride with the parent/guardian.
  - 3. When school transportation is not provided and alternate means are approved by the district.
- e. A display of unsportsmanlike conduct toward an opponent or official or use of profanity during a practice or contest will result in counseling by the head coach and possible suspension from team.
- f. Athletes are expected to attend all practice sessions and contests. Unexcused absence from scheduled practice/contest will result in:
  - 1. Counseling by the head coach and notification of parents by the coach, if necessary.
  - 2. Subsequent violations may result in suspension from the team and possible dismissal for the remainder of the season.
- g. Any violation of the Bethlehem Area School District Code of Conduct and/or academic procedures which require administrative action will be handled in accordance with the provisions of such guidelines. (For example: If a violation involves a three-day suspension, the athlete will be suspended from contests of that team for those three days.)

Any specific injury claim should be directed to the respective school.

## VI. PARENT AND COACH COMMUNICATION GUIDELINES

*Parent-coach relationship: Both parenting and coaching are extremely difficult vocations. By establishing an understanding of each position, we are better able to accept the actions of the other and provide greater benefit to children. Parents, whose children are involved in our athletic program, have the right to understand what expectations are placed on their child. This begins with clear communication from the coach of the child's program.*

- a. **Appropriate concerns to discuss with parents**
1. The treatment of their child, mentally and physically
  2. Ways to help their child improve
  3. Concerns about their child's behavior

It is very difficult for parents to accept their child not playing as much as they may hope. You must make judgment decisions based on what you believe to be the best for all students involved. Coaches must be professional in dealing with parents in all matters involving their children.

- b. **Issues not appropriate to discuss with parents**
1. Playing time
  2. Team strategy
  3. Play calling
  4. Other student athletes

There are situations that may require a conference between the coach and the parent. These are to be encouraged. It is important that both parties have a clear understanding of the other's position. When these conferences are necessary, please call to set up an appointment.

Liberty High School	-- 610-691-7200 x 50951
Freedom High School	-- 610-867-5843 x 53951
Broughal Middle School	-- 610-866-5041
East Hills Middle School	-- 610-867-0541
Nitschmann Middle School	-- 610-866-5781
Northeast Middle School	-- 610-868-8581

- (c) **Extra-curricular Season** – the specified duration of time the activity/club is scheduled to meet. Year long activities will be considered on a semester-by-semester basis.
- (d) **Hazing** – any activity that recklessly, intentionally or unintentionally endangers the mental health, physical health or safety of a student for the purpose of initiation or membership in, or affiliation with any organization including but not limited to a sport or extra-curricular activity recognized by the Board of School Directors.

Endangering the physical health includes but is not limited to any contact of a physical nature such as whipping; beating; branding; forced calisthenics; exposure to the elements; forced consumption of any food, alcoholic beverage, drug, or controlled substance, or other forced activity that could adversely affect the physical health or safety of the individual.

Endangering the mental health includes but is not limited to any activity that would subject an individual to unusual mental stress, such as sleep deprivation, prolonged exclusion from social contact, forced conduct which might result in extreme embarrassment, or any activity which could adversely affect the mental health or dignity of the individual. Any activity, if made part of an initiation, shall be presumed to be hazing, even if the participant willingly participates.

- (e) **Probation** – imposed for school related offenses that result in students being ineligible to participate in extra-curricular activities until such probation is formally lifted by the board or administration.
- (f) **Review Committee** – body to conduct informal hearings, comprised of two building administrators, the assistant superintendent, and the athletic director/activity advisor.
- (g) **Sport Season** – the interval commencing with the approved PIAA starting date of practice or the first day of practice, whichever is later, and terminating with the final competitive event for the sport.
- (h) **Substantiated** – found to have committed a stated offense based on an investigation of the event and evidence gathered.
- (i) **Uniform** – articles of clothing, or equipment in possession bearing the school or school district name, symbols, or markings making it possible to distinguish a person's affiliation to the school or school district.

## **GENERAL GUIDELINES**

The actions and consequences noted below are to be read in addition to and in conjunction with the applicable board policies and the *BASD K-12 Student Code of Conduct*. The actions listed below represent serious violations and may result in the consequences as listed with each action in addition to penalties imposed through the *K-12 Student Code of Conduct*.

1. *Possessing, using, delivering, or selling alcohol or any controlled substance as defined by the Controlled Substance, Drug, Device, and Cosmetic Act while on school property, or at a school sponsored activity, or while on the way to or from a school sponsored activity, or in uniform regardless of location. The term possession includes but is not limited to having*

- b) Second offense results in suspension from any activity as defined under these guidelines.
- c) The student must request a reinstatement review with the building principal to have the suspension(s) from activities lifted. Should reinstatement take place, the student may not assume a leadership role within the organization such as squad captain, section leader, officer position, and the like.

4. *Possessing or using tobacco in any form while on school or while attending, or participating in a school-sponsored activity.*

Consequence:

- a) As defined in the *K-12 Student Code of Conduct* and other penalties as allowed by district policy.
- b) First offense results in activity suspension for a period of not less than five (5) calendar days.
- c) Second offense results in activity suspension from any activities as defined under these guidelines for ten (10) calendar days.
- d) A subsequent offense will result in additional suspensions or expulsion from the activity for the remainder of the season.

5. *Intentional damage (vandalism) or theft of school or person's property from any location on school property or off school property during any school sponsored event or related to any school sponsored activity.*

Consequence:

- a) As defined in *K-12 Student Code of Conduct*, see district discipline for possible penalties including administrative probation, suspension, or expulsion depending on the severity of the offense and other penalties, including referral to law enforcement authorities as allowed by district policy.
- b) Immediate activity suspension from any activities as defined under these guidelines for up to seven (7) calendar days, depending on severity of the incident, payment of restitution, or return of property.

6. *Failure to return activity equipment.*

Consequence:

- a) Suspension from any activity program participation as defined under these guidelines until equipment is returned or paid for.

7. *Acts that constitute a violation of the applicable criminal code(s) whether or not delineated as part of the K-12 Student Code of Conduct.*

Consequence:

- a) As defined in *K-12 Student Code of Conduct* as applicable.

The superintendent or designee has complete discretion whether or not to hear the appeal. If the superintendent or designee decides to hear the appeal, such meeting shall be conducted within ten (10) business days of the date of the appeal. If such meeting is granted, the initial disciplinary action will remain in effect. The appeal meeting shall be informal and the decision of the superintendent or his/her designee shall be final.

- (5) Once a suspension or activity expulsion has been imposed, the student will not be permitted to participate in any activity unless the recommendation for suspension/expulsion is reversed after appeal.
- (6) An expulsion includes forfeiture of any school related awards for that season.
- (7) Nothing in the code shall preclude any building principal or assistant principal from suspending or excluding a student from an activity for any violation of the disciplinary rules of the Bethlehem Area School District even if the offense committed by the student would also be an offense under the terms of the *K-12 Student Code of Conduct*.
- (8) These penalties for policy infractions and discipline imposed there under are not limited to the season in which the infraction occurred.

A coach may set additional reasonable, discipline and attendance requirements at the beginning of the season.

**PARTICIPATION IN ALL SPORTS REQUIRES AN ACCEPTANCE OF RISK OF POSSIBLE INJURY. YOUR CHILD, AS A PLAYER, CAN HELP MAKE THE GAME SAFER BY NOT INTENTIONALLY USING TECHNIQUES WHICH ARE ILLEGAL AND WHICH CAN CAUSE SERIOUS INJURY.**

Please do not hesitate to contact the Athletic Office if we can help you or your child in any way during his/her athletic career with the Bethlehem Area School District.

Thank you for your kind cooperation in this very important matter.

Freedom High School Athletic Office: 610-867-5843 x53951

Liberty High School Athletic Office: 610-691-7200 x50951

Sincerely,

Bethlehem Area School District  
Department of Athletics

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(PLEASE SIGN BASD POLICY LETTER- ACKNOWLEDGEMENT FORM LOCATED ON THE FRONT OF THIS PACKET AND RETURN WITH PHYSICAL PAPERS)