Central Dauphin School District

Sports Re-certification Packet

SPRING - 2023

TURN IN COMPLETED PACKET TO THE ATHLETIC TRAINER

Student's Name: _____ School Enrolled: _____

Gender: _____ Participating in sports at: (Circle): CDEHS / CDHS / CDEMS-SMS / CDMS-LMS

DOB/Age: _____/_____ Grade level at time sport season begins: (Circle) 7 8 9 10 11 12

Sport this Season: _____ Season: (Circle) Winter Spring

Re-Certification Packet Directions:

- Packet must be fully completed and turned in as the **signed originals**. *NO copies/faxes will be accepted.*
- Students turning in a Re-certification packet must:
  - Have **completed CDSD/PIAA Physical Packet** on file from previous season
  - Have all paperwork **signed, completed, and turned in as originals** prior to sports participation
  - **If you sought medical attention during the previous sport(s) season or marked 'yes' to any questions on Section 7, a Section 8 must be completed by an MD/DO**
  - Re-Certification Packets need to be dated after **MONDAY, JANUARY 23, 2023.**

- **ALL Paperwork must be turned in NO LATER THAN WEDNESDAY, MARCH 1, 2023.**

- NO STUDENT MAY TRY-OUT/PARTICIPATE IN A SPORT UNTIL BEING "CLEARED" BY AN AUTHORIZED MEDICAL EXAMINER ON THE PIAA CIPPE/CDSD PHYSICAL PACKET AND SAID FORMS ARE REVIEWED/APPROVED BY THE APPROPRIATE PERSONNEL AT THEIR RESPECTIVE SCHOOL. ImPACT BASELINE TESTING MUST BE COMPLETED PRIOR TO TRY-OUT/PARTICIPATION FOR HIGH SCHOOL STUDENTS AS WELL.

Additional information and date(s) of sports physicals and ImPACT Baseline Concussion testing can be found at: www.cdschools.org

Certain Medical Conditions requiring additional paperwork prior to participation:

YES NO My child has one of the following conditions:

____ Asthma (either controlled or exercise-induced) or Reactive Airway Disease

____ Severe Allergic Reaction requiring use of an Epi-Pen

____ Diabetes

Has this condition change since their last sports physical? (Circle) YES NO

(If you marked **YES** to any of the above questions please fill out the **Certain Medical Conditions Page** completely and turn it in with this packet.)

Is the additional paperwork for this school year on file with the nurse? (Circle) YES NO

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____

Revised: 1-12-2023

CENTRAL DAUPHIN SCHOOL DISTRICT
INTERSCHOLASTIC ATHLETICS
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please read the following statements and sign below:

I **hereby authorize** the use or disclosure of my individually identifiable Protected Health Information (PHI) as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or health care provider, the release of information may no longer be protected by Health Insurance Portability and Accountability Act (HIPAA) regulations. The PHI may be re-disclosed by the recipient as appropriate according to Family Educational Rights and Privacy Act (FERPA), which is a Federal law that protects the privacy of student educational records.

Organization Providing the Information: Central Dauphin School District appointed Physician(s), Student-Athlete's Primary Physician, any Physician serving a Central Dauphin School District Student Athlete, and the Student Athlete's Nurse(s) or Certified Athletic Trainer(s) at their school building of attendance.
Organization(s) or Person(s) Receiving the Information: Central Dauphin School District appointed Physician(s) and the Certified Athletic Trainer(s), Nurse(s), Coaches, and Athletic Director at the student athlete's school building of attendance.
Specific Description of Information Disclosed: All medical and individually identifiable Protected Health Information (PHI) relating to any sports injury, including but not limited to diagnosis, treatment, prognosis, likelihood and timing of recovery and recommendations concerning ability to play competitively and safely.
Purpose of Disclosure: To apprise Central Dauphin School District appointed Physician(s), and the Certified Athletic Trainer(s), Nurse(s), Coaches, and Athletic Director at the student athletes school building of attendance about the extent and nature of any sports-related injury for the purpose of rehabilitation, training, recovery, and ability to play competitively and safely.

I **understand this authorization** will expire one year from the signed date, or on the graduation date from the current educational institution high school, whichever shall first occur.

I **understand** that I may revoke this Authorization at any time by notifying Central Dauphin School District's appointed Physician(s) in writing, but if I do, it will not have any affect on any actions Central Dauphin School District's appointed Physician(s) took before he/she received the revocation.

ACKNOWLEDGEMENT OF A SCHOOL OFFERED SPORTS PHYSICAL EVALUTATION
Central Dauphin School District Appointed Physicians
Francis X. Brescia, JR., DO., FACOFP Amy L. Zellers, D.O.

I/We **hereby** acknowledge that if my child attends one of the school-offered sports physical evaluations that he/she is receiving either a pre-participation evaluation or recertification prior to participating in athletics at this institution. This evaluation **does not** replace the need for annual well child examination with their regular **primary care provider.** This screening **does not** address routine health care needs such as recommended immunizations, nor does it include evaluation and testing for such things as childhood obesity or other childhood problems. I/We understand that I/We are strongly encouraged to continue annual checkups with your child's primary care provider. Further, I/We understand that should any of the CDSD appointed physicians during my child's pre-participation evaluation or recertification find them not fit to participate, I/We will obtain further evaluation at our expense from our primary care provider or specialist and furnish any required records or reports from these healthcare professionals who have examined or treated my child.

_____ _____
Athlete Date

_____ _____
Parent/Guardian Date

Only CDSD and PIAA approved forms for sports physicals will be accepted. These must be the signed originals. NO PHOTOCOPIES OR FAXES ACCEPTED.
Revised July 2018

ACKNOWLEDGMENT OF RISK, RELEASE AND WAIVER OF LIABILITY AND CONSENT TO PARTICIPATE

I/We hereby acknowledge that participation in athletics involves a risk of injury. I/We understand that this risk includes severe injuries possibly involving paralysis, permanent mental disability, or death, and that these injuries may occur, in some instances, as a result of avoidable accidents.

I/We assume these risks including, but not limited to: 1) risk of injury associated with the use of District equipment in conjunction with athletic activities, 2) risk of injury arising from participation in supervised or unsupervised athletic activities and programs, including tryouts, games, scrimmages, practices and training, and 3) risk of injury or medical disorder resulting from participation in the athletic activity.

I/We expressly waive, disclaim, and release CDSD, its directors, agents, employees, and representatives from and against any claims of any kind whatsoever, including, but not limited to, claims of negligence, costs, liabilities, expenses and judgments, related to any injury sustained as a result of the participation in athletics.

By signing this agreement, I affirm that I have read and understand the terms of the agreement and that I/We give consent to participate in athletic activities during the season.

_____

Parent/Guardian's Printed Name

_____ _____

Parent/Guardian's Signature Date

_____ _____

Student Athlete's Signature Date

SECTION 8: RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal, or the Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY.

If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the herein named student shall submit a completed Section 9, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

SUPPLEMENTAL HEALTH HISTORY

Student's Name _____ Male/Female (circle one)

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

Winter Sport(s): _____ Spring Sport(s): _____

CHANGES TO PERSONAL INFORMATION (In the spaces below, identify any changes to the Personal Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Current Home Address _____

Current Home Telephone # ( )_____ Parent/Guardian Current Cellular Phone # ( )_____

CHANGES TO EMERGENCY INFORMATION (In the spaces below, identify any changes to the Emergency Information set forth in the original Section 1: PERSONAL AND 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 # ( )_____

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 9, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.
Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

	Yes	No
1. Since completion of the CIPPE, have you sustained a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine?	☐	☐
An additional note to item #1, if serious illness or serious injury was marked "Yes", please provide additional information below		
2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?	☐	☐
4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	☐	☐
5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills?	☐	☐
6. Do you have any concerns that you would like to discuss with a physician?	☐	☐

#'s	Explain yes answers; include injury, type of treatment & the name of the medical professional seen by student

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 9: Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine

This Form must be completed for any student who, subsequent to completion of Sections 1 through 6 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 9 may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to the Principal, or the Principal's designee, of the student's school, who, pursuant to ARTICLE X, LOCAL MANAGEMENT AND CONTROL, Section 2, Powers and Duties of Principal, subsection C, of the PIAA Constitution, shall "exclude any contestant who has suffered serious illness or injury until that contestant is pronounced physically fit by the school's licensed physician of medicine or osteopathic medicine, or if none is employed, by another licensed physician of medicine or osteopathic medicine."

NOTE: The physician completing this Form must first review Sections 6 and 7 of the herein named student's previously completed CIPPE Form. Section 8 must also be reviewed if both (1) this Form is being used by the herein named student to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in a subsequent sport season in the same school year AND (2) the herein named student either checked yes or circled any Supplemental Health History questions in Section 8.

If the physician completing this Form is clearing the herein named student subsequent to that student sustaining a concussion or traumatic brain injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.

Student's Name: _____ Age_____Grade_____

Enrolled in _____School

Condition(s) Treated Since Completion of the Herein Named Student's CIPPE Form: _____

_____

_____

_____

_____

A. GENERAL CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with no restrictions, except those, if any, set forth in Section 6 of that student's CIPPE Form.

Physician's Name (print/type)_____ License #_____

Address_____ Phone ( )_____

Physician's Signature _____MD or DO *(circle one)* Date_____

B. LIMITED CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with, in addition to the restrictions, if any, set forth in Section 6 of that student's CIPPE Form, the following limitations/restrictions:

1. _____
2. _____
3. _____
4. _____

Physician's Name (print/type)_____ License #_____

Address_____ Phone ( )_____

Physician's Signature _____MD or DO *(circle one)* Date_____

Central Dauphin School District

Certain Medical Conditions Medication Form

Student's Name: _____ School Enrolled: _____

DOB: _____ Participating in sports at: (Circle): CDEHS / CDHS / CDEMS-SMS / CDMS-LMS

Grade level at time sport season begins: (Circle) 7 8 9 10 11 12 Sport(s): _____

Central Dauphin School District requires that any student-athlete diagnosed with a medical condition such as asthma, reactive airway disease, diabetes, or severe allergic reactions requiring use of an epi-pen must have that medication present at all practices and events. Yearly, parent(s)/guardian(s) must fill out the Certain Medical Conditions Form and return it prior to the student-athlete's participation. The medication must be labeled clearly with the student-athlete's name and kept in a specific location for each practice and event as designated by the team physician, athletic trainer, athletic director, or coach. Any student-athlete found without his/her medication can be removed from practice/event and not allowed to participate until medication is produced and placed in specific location. Forms will be shared between athletic trainers and school nurses.

Condition(s):

____ Asthma (either controlled or exercise-induced) or Reactive Airway Disease

____ Severe Allergic Reaction requiring use of an Epi-Pen

____ Diabetes

Name of Medication(s): _____

Dosage(s)/ Route of administration/dose time(s): _____

_____

_____

YES NO I have verified that the student-athlete has been instructed on how to self-administer medication(s).

YES NO Student-athlete has my permission to carry and self-administer above mentioned medication(s).

Physician's Signature: _____ Date: _____

YES NO I understand that my student-athlete has been instructed on how to self-administer medication(s).

YES NO Student-athlete has my permission to carry and self-administer above mentioned medication(s).

Parent's Signature: _____ Date: _____

Revised: 4/12/2018