



**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 seven Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, 5 and 6 by the student and parent/guardian; and Section 7 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st 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 8 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 9 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 # () _____

Parent/Guardian E-mail Address: _____

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, 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 7 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) occurs when the heart suddenly and unexpectedly stops beating. 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 350,000 cardiac arrests that occur outside of hospitals each year. More than 10,000 individuals under the age of 25 die of SCA each year. SCA is the number one killer of student athletes and the leading cause of death on school campuses.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as

- Dizziness or lightheadedness when exercising;
- Fainting or passing out during or after exercising;
- Shortness of breath or difficulty breathing with exercise, that is not asthma related;
- Racing, skipped beats or fluttering heartbeat (palpitations)
- Fatigue (extreme or recent onset of tiredness)
- Weakness;
- Chest pains/pressure or tightness during or after exercise.

These symptoms can be unclear and confusing in athletes. Some may ignore the signs or think they are normal results off physical exhaustion. If the conditions that cause SCA are diagnosed and treated before a life-threatening event, sudden cardiac death can be prevented in many young athletes.

What are the risks of practicing or playing after experiencing these symptoms?

There are significant risks associated with continuing to practice or play after experiencing these symptoms. The symptoms might mean something is wrong and the athlete should be checked before returning to play. When the heart stops due to cardiac arrest, 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 experience a SCA die from it; survival rates are below 10%.

Act 73 – Peyton's Law - Electrocardiogram testing for student athletes

The Act is intended to help keep student-athletes safe while practicing or playing by providing education about SCA and by requiring notification to parents that you can request, at your expense, an electrocardiogram (EKG or ECG) as part of the physical examination to help uncover hidden heart issues that can lead to SCA.

Why do heart conditions that put youth at risk go undetected?

- Up to 90 percent of underlying heart issues are missed when using only the history and physical exam;
- Most heart conditions that can lead to SCA are not detectable by listening to the heart with a stethoscope during a routine physical; and
- Often, youth don't report or recognize symptoms of a potential heart condition.

What is an electrocardiogram (EKG or ECG)?

An ECG/EKG is a quick, painless and noninvasive test that measures and records a moment in time of the heart's electrical activity. Small electrode patches are attached to the skin of your chest, arms and legs by a technician. An ECG/EKG provides information about the structure, function, rate and rhythm of the heart.

Why add an ECG/EKG to the physical examination?

Adding an ECG/EKG to the history and physical exam can suggest further testing or help identify up to two-thirds of heart conditions that can lead to SCA. An ECG/EKG can be ordered by your physician for screening for cardiovascular disease or for a variety of symptoms such as chest pain, palpitations, dizziness, fainting, or family history of heart disease.

- ECG/EKG screenings should be considered every 1-2 years because young hearts grow and change.
- ECG/EKG screenings may increase sensitivity for detection of undiagnosed cardiac disease but may not prevent SCA.
- ECG/EKG screenings with abnormal findings should be evaluated by trained physicians.
- If the ECG/EKG screening has abnormal findings, additional testing may need to be done (with associated cost and risk) before a diagnosis can be made, and may prevent the student from participating in sports for a short period of time until the testing is completed and more specific recommendations can be made.
- The ECG/EKG can have false positive findings, suggesting an abnormality that does not really exist (false positive findings occur less when ECG/EKGs are read by a medical practitioner proficient in ECG/EKG interpretation of children, adolescents and young athletes).
- ECGs/EKGs result in fewer false positives than simply using the current history and physical exam.

The American College of Cardiology/American Heart Association guidelines do not recommend an ECG or EKG in asymptomatic patients but do support local programs in which ECG or EKG can be applied with high-quality resources.

Removal from play/return to play

Any student-athlete who has signs or symptoms of SCA must be removed from play (which includes all athletic activity). The symptoms can happen before, during, or after activity.

Before returning to play, the athlete must be evaluated and cleared. 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 this form and understand the symptoms and warning signs of SCA. I have also read the information about the electrocardiogram testing and how it may help to detect hidden heart issues.

Signature of Student-Athlete

Print Student-Athlete's Name

Date____/____/____

Signature of Parent/Guardian

Print Parent/Guardian's Name

Date____/____/____

Section 5: SUPPLEMENTAL ACKNOWLEDGEMENT, WAIVER AND RELEASE: COVID-19

The COVID-19 pandemic presents athletes with a myriad of challenges concerning this highly contagious illness. Some severe outcomes have been reported in children, and even a child with a mild or even asymptomatic case of COVID-19 can spread the infection to others who may be far more vulnerable.

While it is not possible to eliminate all risk of being infected with or furthering the spread of COVID-19, PIAA has urged all member schools to take necessary precautions and comply with guidelines from the federal, state, and local governments, the CDC and the PA Departments of Health and Education to reduce the risks to athletes, coaches, and their families. As knowledge regarding COVID-19 is constantly changing, PIAA reserves the right to adjust and implement precautionary methods as necessary to decrease the risk of exposure to athletes, coaches and other involved persons. Additionally, each school has been required to adopt internal protocols to reduce the risk of transmission.

The undersigned acknowledge that they are aware of the highly contagious nature of COVID-19 and the risks that they may be exposed to or contract COVID-19 or other communicable diseases by permitting the undersigned student to participate in interscholastic athletics. We understand and acknowledge that such exposure or infection may result in serious illness, personal injury, permanent disability or death. We acknowledge that this risk may result from or be compounded by the actions, omissions, or negligence of others. The undersigned further acknowledge that certain vulnerable individuals may have greater health risks associated with exposure to COVID-19, including individuals with serious underlying health conditions such as, but not limited to: high blood pressure, chronic lung disease, diabetes, asthma, and those whose immune systems that are compromised by chemotherapy for cancer, and other conditions requiring such therapy. While particular recommendations and personal discipline may reduce the risks associated with participating in athletics during the COVID-19 pandemic, these risks do exist. Additionally, persons with COVID-19 may transmit the disease to others who may be at higher risk of severe complications.

By signing this form, the undersigned acknowledge, after having undertaken to review and understand both symptoms and possible consequences of infection, that we understand that participation in interscholastic athletics during the COVID-19 pandemic is strictly voluntary and that we agree that the undersigned student may participate in such interscholastic athletics. The undersigned also understand that student participants will, in the course of competition, interact with and likely have contact with athletes from their own, as well as other, schools, including schools from other areas of the Commonwealth. Moreover, they understand and acknowledge that our school, PIAA and its member schools cannot guarantee that transmission will not occur for those participating in interscholastic athletics.

NOTWITHSTANDING THE RISKS ASSOCIATED WITH COVID-19, WE ACKNOWLEDGE THAT WE ARE VOLUNTARILY ALLOWING STUDENT TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS WITH KNOWLEDGE OF THE DANGER INVOLVED. WE HEREBY AGREE TO ACCEPT AND ASSUME ALL RISKS OF PERSONAL INJURY, ILLNESS, DISABILITY AND/OR DEATH RELATED TO COVID-19, ARISING FROM SUCH PARTICIPATION, WHETHER CAUSED BY THE NEGLIGENCE OF PIAA OR OTHERWISE.

We hereby expressly waive and release any and all claims, now known or hereafter known, against the student's school, PIAA, and its officers, directors, employees, agents, members, successors, and assigns (collectively, "Releasees"), on account of injury, illness, disability, death, or property damage arising out of or attributable to Student's participation in interscholastic athletics and being exposed to or contracting COVID-19, whether arising out of the negligence of PIAA or any Releasees or otherwise. We covenant not to make or bring any such claim against PIAA or any other Releasee, and forever release and discharge PIAA and all other Releasees from liability under such claims.

Additionally, we shall defend, indemnify, and hold harmless the student's school, PIAA and all other Releasees against any and all losses, damages, liabilities, deficiencies, claims, actions, judgments, settlements, interest, awards, penalties, fines, costs, or expenses of whatever kind, including attorney fees, fees, and the costs of enforcing any right to indemnification and the cost of pursuing any insurance providers, incurred by/awarded against the student's school, PIAA or any other Releasees in a final judgment arising out or resulting from any claim by, or on behalf of, any of us related to COVID-19.

We willingly agree to comply with the stated guidelines put forth by the student's school and PIAA to limit the exposure and spread of COVID-19 and other communicable diseases. We certify that the student is, to the best of our knowledge, in good physical condition and allow participation in this sport at our own risk. By signing this Supplement, we acknowledge that we have received and reviewed the student's school athletic plan.

Date: _____

Signature of Student

Print Student's Name

Signature of Parent/Guardian
Revised – October 7, 2020

Print Parent/Guardian's Name

SECTION 6: HEALTH HISTORY

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

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<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"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<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"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<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"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you ever had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that apply):			CONCUSSION OR TRAUMATIC BRAIN INJURY 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"/> FEMALES ONLY 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"/>		
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> High cholesterol <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?					
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"/>			
<div style="display: flex; justify-content: space-between; font-size: small;"> Head Neck Shoulder Upper arm Elbow Forearm Hand/Fingers Chest </div> <div style="display: flex; justify-content: space-between; font-size: small;"> Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/Toes </div>					
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"/>			

#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 7: 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 ____/____/____

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 _____

Parent/Guardian E-mail Address: _____

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? | <input type="checkbox"/> | <input type="checkbox"/> |

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? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any concerns that you would like to discuss with a physician? | <input type="checkbox"/> | <input type="checkbox"/> |

#'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 7 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 7 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 _____

Section 10: CIPPE MINIMUM WRESTLING WEIGHT

INSTRUCTIONS

Pursuant to the Weight Control Program adopted by PIAA, prior to the participation by any student in interscholastic wrestling, the Minimum Wrestling Weight (MWW) at which the student may wrestle during the season must be (1) certified to by an Authorized Medical Examiner (AME) and (2) established NO EARLIER THAN six weeks prior to the first Regular Season Contest day of the wrestling season and NO LATER THAN the Monday preceding the first Regular Season Contest day of the wrestling season (See NOTE 1). This certification shall be provided to and maintained by the student's Principal, or the Principal's designee.

In certifying to the MWW, the AME shall first make a determination of the student's Urine Specific Gravity/Body Weight and Percentage of Body Fat, or shall be given that information from a person authorized to make such an assessment ("the Assessor"). This determination shall be made consistent with National Federation of State High School Associations (NFHS) Wrestling Rule 1, Competition, Section 3, Weight-Control Program, which requires, in relevant part, hydration testing with a specific gravity not greater than 1.025, and an immediately following body fat assessment, as determined by the National Wrestling Coaches Association (NWCA) Optimal Performance Calculator (OPC) (together, the "Initial Assessment").

Where the Initial Assessment establishes a percentage of body fat below 7% for a male or 12% for a female, the student must obtain an AME's consent to participate.

For all wrestlers, the MWW must be certified to by an AME.

Student's Name _____ Age _____ Grade _____
Enrolled in _____ School _____

INITIAL ASSESSMENT

I hereby certify that I have conducted an Initial Assessment of the herein named student consistent with the NWCA OPC, and have determined as follows:

Urine Specific Gravity/Body Weight _____ / _____ Percentage of Body Fat _____ MWW _____

Assessor's Name (print/type) _____ Assessor's I.D. # _____

Assessor's Signature _____ Date ____ / ____ / ____

CERTIFICATION

Consistent with the instructions set forth above and the Initial Assessment, I have determined that the herein named student is certified to wrestle at the MWW of _____ during the 20____ - 20____ wrestling season.

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

Address _____ Phone () _____

AME's Signature _____ MD, DO, PAC, CRNP, or SNP Date of Certification ____ / ____ / ____
(circle one)

For an appeal of the Initial Assessment, see NOTE 2.

NOTES:

1. For senior high school wrestlers coming out for the Team AFTER the Monday preceding the first Regular Season Contest day of the wrestling season the OPC will remain open until January 15th and for junior high/middle school wrestlers coming out for the Team AFTER the Monday preceding the first Regular Season Contest day of the wrestling season the OPC will remain open all season.
2. Any athlete who disagrees with the Initial Assessment may appeal the assessment results one time by having a second assessment, which shall be performed prior to the athlete's first Regular Season wrestling Contest and shall be consistent with the athlete's weight loss (descent) plan. Pursuant to the foregoing, results obtained at the second assessment shall supersede the Initial Assessment; therefore, no further appeal by any party shall be permitted. The second assessment shall utilize either Air Displacement Plethysmography (Bod Pod) or Hydrostatic Weighing testing to determine body fat percentage. The urine specific gravity testing shall be conducted and the athlete must obtain a result of less than or equal to 1.025 in order for the second assessment to proceed. All costs incurred in the second assessment shall be the responsibility of those appealing the Initial Assessment.



IMPORTANT: This form

accompanies student athlete

to all events.

Emergency Card for Athletes

- Emergency card/authorization for each athlete must accompany the athlete at all times.
- The card for each athlete should be carried in the first-aid kit for each sport.
- The card for each athlete should be readily accessible to the Coach, athletic trainer, or emergency personnel.
- Prior to the start of each sport, the card for each athlete should be reviewed by the Coach/trainer/athletic director or any other medical personnel for completeness.
- Include emergency phone numbers or significant medical history.

Please complete the information below prior to participation in each sports' season:

Name: _____ DOB: _____ AGE: _____

Address: _____ EMAIL: _____

City, State, Zip: _____

Telephone: _____

Blood Type: _____

In case of accident or emergency, please contact:

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 # () _____

Pre-Existing Circulatory/Pulmonary Conditions: _____

Diabetes: _____

Inhalers: _____

Allergies or Allergic Reactions: _____

Medications Being Used: _____

Date of Tetanus Immunization: _____

Have you ever had a concussion (i.e. bell rung, ding, head rush) or head injury? _____ Yes _____ No

Other Pertinent Information: _____

Permission to Treat: _____ Parent's/Guardian's Signature

Print Athlete's Name

Sport 1: _____ Sport 2: _____ Sport 3: _____
Print Athlete's Sport(s)

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

(1) UPMC Authorization for Release of Protected Health Information

- I authorize UPMC to provide information related to the athlete's care to family/school/team physicians, school nurses, coaches, athletic directors, school principals, EMS personnel, and such other persons as is necessary needed for them to provide consultation, treatment, establish a plan of care or determine whether the athlete may resume participation in school or sports activities.
- I authorize UPMC to use the athlete's medical information for UPMC internal departmental reporting purposes.
- I authorize UPMC (including its hospitals, other entities and programs) to use medical or other information maintained on electronic information systems or stored in various forms about the athlete's care, health care operations, or payment for treatment and services.
- I understand that the health record(s) released by UPMC may be re-disclosed by the facility/person that receives the record(s) and therefore (1) UPMC and its staff/employees has no responsibility or liability because of the re-disclosure and (2) such information may no longer be protected by federal or state privacy laws.
- I understand that this Authorization is in effect for a period of one year from the date signed by the athlete.
- I understand that this Authorization is in effect if the athlete is treated for an injury during off-season workouts; however, no time frame specified shall go beyond one year from the date of signature.
- I understand that I have the right to revoke this Authorization form at any time by sending a written request to UPMC at the location where the Authorization was provided.
- I understand that my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization. • I understand that I am entitled to a copy of this completed Authorization form.

Print Athlete's NameSport 1: _____ Sport 2: _____ Sport 3: _____
Print Athlete's Sport(s)

(2) UPMC Consent for Treatment and Healthcare Operations

I consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic injuries. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team physician, school nurse, and licensed physical therapists. Under the direction of a certified athletic trainer, college/university athletic training students and high school student aides may also provide care.

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

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

(3) UPMC Privacy Practices

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

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

Athlete signature

Date

Parent or guardian signature/relationship

Date

Parent or guardian signature/relationship

Date

For Office Use Only:

Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices: _____

Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices:

CANTON HIGH SCHOOL ATHLETIC, EXTRA & CO-CURRICULAR CODE OF CONDUCT



UPDATED: 3/2022

Mission: We, in the Canton Area School District, believe that a healthy mind and healthy body complement one another. We also believe that learning is not to be limited to the classroom and that participation, athletics and competition, in their proper place and perspective, are other components of the learning process. Therefore, we believe that interscholastic athletics and co-curricular activities should be incorporated into our total educational offerings as integral parts

General Objective: Games and events should have as their chief purposes, friendly rivalries, creation of new friendships, playing skills, good sportsmanship, and improved community relations.

Specific Objectives

Interscholastic Athletics and Co-Curricular Activities at Canton High School

- Provide opportunities to develop skill and to experience the satisfaction of performing effectively in emotionally charged situations.
- Contribute to the development of a health and fitness attitude that will provide a carry-over interest, which will function during leisure time.
- Contribute to the development of a wholesome appreciation for a well-developed and properly conditioned body.
- Contribute to the development of desirable social and citizenship qualities such as responsibility, respect for authority, leadership and fellowship abilities, respect for the rights and properties of others, harmonious and cooperative group action and respect for individual differences.
- Contribute to the satisfaction of certain psychological needs such as: self-understanding, self-expression, recognition and approval.
- Contribute to the development of desirable character traits including persistence, determination, unselfishness, will-to-win, alertness, maximum effort, resourcefulness and tenacity.
- Promote the development of the self-esteem and self-realization of each participant.

Objectives for School and Student body

- Interscholastic athletics and co-curricular activities should occupy a position in the curriculum comparable to that of other subjects or activities.
- Interscholastic athletics and co-curricular activities should be educational.
- Interscholastic athletics and co-curricular activities should be a means of promoting fine school morals.
- All visiting schools should be treated as guests.
- Interscholastic athletic programs and co-curricular activities should be broad rather than narrow in scope.
- Sportsmanship, fair play, and good school citizenship should be objectives of all participants.

Code of Conduct for Participants in Interscholastic Athletics & Co-Curricular Activities

- Appreciate that coaches, advisors, sponsors, and administrators have the best interests of the participants in mind as they plan and conduct their programs.
- Obey the specific training and practice rules of the coach, advisor, or sponsor.
- Be present at practice sessions, rehearsals, games, and scheduled events unless excused by the coach, advisor, or sponsor.
- Practice healthful habits of cleanliness and personal hygiene in all their daily activities.
- Appreciate the importance of proper rest, diet, and exercise.
- Understand that alcohol, tobacco, and illegal/illicit drugs are harmful to the body and mind, and hinder maximum effort and performance.
- Participants should appear neat and well groomed at all times.
- Participants should not use profanity or other inappropriate language/gestures
- Directly represent the coaches, advisors, sponsors, school, community, and should conduct themselves properly at all times. Student/student athletic conduct reflects on the school's reputation.
- Realize that officials do not lose a contest but are there for the purposes of ensuring that both teams/individuals receive a fair deal. For this, they deserve and will receive our courteous respect.
- Do not employ illegal tactics to gain an undeserved advantage.
- Have a good attendance record and will not skip class(es) or be truant from school.
- Care for all equipment as though it were their own personal property. Any loss of or damage to issued equipment (other than normal use/wear) is the participant's responsibility. Students will be held financially responsible for all replacement costs.
- Show sportsmanship at all times and express the importance of teamwork over personal recognition.
- Comply with the standards of the Student Code of Conduct

Sanctions from the Code of Conduct

- Minor Infractions- First infractions of a minor nature, as well as, continued minor infractions should be punishable by the coach/director in a fair but stern manner and commensurate with the seriousness of the infraction. Suggested punishments for minor infractions include, but are not limited to, warnings, conferences, and /or review of the code, loss of assigned responsibilities, probationary status or ineligibility for one or more contests.
- Major Infractions-Infractions of the student code of conduct are considered major and should be reported to the Athletic Director immediately. These infractions include acts of violence, weapons, terroristic threats, controlled substances, alcohol, tobacco and vaping products. Major infractions should be punishable by the administration in a fair but stern manner and commensurate with the seriousness of the infraction according to the information provided below.

- **School Attendance**

A student must be in good standing (academically eligible) in the school to participate in interscholastic athletics or co-curricular activities. Academic eligibility as defined by the PIAA and the CHS "Pass to Play" program. The Pennsylvania Interscholastic Athletic Association dictates the ineligibility of any student who does not comply with the established regulations.

- **Use, Possession or Sale of Tobacco or Vapor Products**

- 1st Violation during the current school year
 - Suspension from participation for 5 school days
 - Successful completion of a school or community based Tobacco education program.
 - Referral to Local Law Enforcement Agency (District Magistrate)
 - Report to Office of Safe Schools (PDE)
- 2nd Violation during the current school year
 - Suspension from participation from the activity for the remainder of season or activity duration
 - Successful completion of a school or community based Tobacco education program.
 - Referral to Local Law Enforcement Agency (District Magistrate)
 - Report to Office of Safe Schools (PDE)
- 3rd Violation during the current school year
 - Suspension from participation in all extra curricular activities for one calendar year
 - Successful completion of a school or community based Tobacco education program.
 - Referral to Local Law Enforcement Agency (District Magistrate)
 - Report to Office of Safe Schools (PDE)

- **Use, Possession or Sale of Illegal drugs, controlled substances or alcoholic beverages** NOTE: Attendance by a student at an event where alcoholic beverages, illegal drugs or controlled substances are provided for or consumed by persons under the age of 21 in the absence or the presence and approval of the parents or guardians of those underage persons is a violation of training rules and is subject to the disciplinary code below.

- 1st Violation during the current school year
 - Immediate Suspension from all extra curricular activities for 45 school days
 - Referral to law enforcement
 - Successful completion of Drug & Alcohol Assessment by a licensed facility
 - Report to Office of Safe Schools (PDE)
- 2nd Violation during the current school year
 - Immediate Suspension from all extra curricular activities for one calendar year

- Referral to law enforcement
 - Successful completion of Drug & Alcohol Assessment by a licensed facility
 - Report to Office of Safe Schools (PDE)
- **Violence Resulting In Serious Bodily Injury**
 - 1st Violation during the current school year
 - Immediate Suspension from all extra curricular activities for 45 school days
 - Referral to law enforcement
 - Completion of a mental health evaluation by the school or other licensed facility
 - Report to Office of Safe Schools (PDE)
 - 2nd Violation during the current school year
 - Immediate Suspension from all extra curricular activities for one calendar year
 - Referral to law enforcement
 - Completion of a mental health evaluation by the school or other licensed facility
 - Report to Office of Safe Schools (PDE)
- **Possession of Weapon(s)**
 - 1st Violation during the current school year
 - Immediate Suspension from all extra curricular activities for **up to** 45 school days
 - Referral to law enforcement
 - Completion of a mental health evaluation by the school or other licensed facility **may be required**
 - Report to Office of Safe Schools (PDE)
 - 2nd Violation during the current school year
 - Immediate Suspension from all extra curricular activities for 45 school days
 - Referral to law enforcement
 - Completion of a mental health evaluation by the school or other licensed facility
 - Report to Office of Safe Schools (PDE)
- **Use, Possession or Sale of Anabolic Steroids**
 - 1st Violation during the current school year
 - Immediate Suspension from all extra curricular activities for the remainder of the season
 - Report to Office of Safe Schools (PDE)
 - Medical determination by a licensed provider confirming no residual evidence of the steroid exists.

- 2nd Violation during the current school year
 - Immediate Suspension from all extra curricular activities for the remainder of the season and the following season
 - Report to Office of Safe Schools (PDE)
 - Medical determination by a licensed provider confirming no residual evidence of the steroid exists.
- 3rd Violation, permanent suspension from school athletics.
 - Immediate and permanent suspension from school athletics for the remainder of high school career
 - Report to Office of Safe Schools (PDE)
- **Court Proceedings, Probation, Law Enforcement Involvement**
 - A student may be declared ineligible to participate in any interscholastic, athletic, and/or co-curricular activity in which he/she represents the school in a public appearance if he/she
 - Has been found delinquent by the courts, found guilty (reached the age of majority) by the courts or has been put on probation by the courts.
 - Conducts himself/herself in a manner that in the opinion of school authorities, would reflect unfavorably upon students.

Apply the sanctions to the Code

A STUDENT'S FAILURE TO ADHERE TO TRAINING RULES AND STANDARDS (CANTON ATHLETICS/CO-CURRICULAR CODE OF CONDUCT AND STUDENT HANDBOOK POLICIES) DESCRIBED HEREIN MAY AMOUNT TO SELF-DISQUALIFICATION FROM INTERSCHOLASTIC ATHLETICS AND/OR CO-CURRICULAR ACTIVITIES. The head coach, coaching staff, adviser, sponsor, chaperones (when authorized) or school administration of necessity, have the right to exercise judgment in matters of enforcing the rules and must apply penalties impartially. The principal will take action on major infractions and matters requiring administrative attention. The athletic director will investigate, review options for sanctions and report, with recommendations to the principal.

Student and Parent Acknowledgement

If I am accepted as a member of a sport or activity(ies) group, I will obey all rules and regulations of the sport/activity(ies) as well as the Canton Athletic/Co-Curricular Code of Conduct. Additionally, I will obey all regulations contained in the Canton Jr./Sr. High School Student Handbook. I realize that failure to meet these requirements will amount to my self-disqualification and dismissal from the sport/activity(ies). As the student, I have read and understand the requirements, rules, and consequences of this code. As a Parent/Legal Guardian, your signature acknowledges the school's scope of authority over our child.

Student Name

Student Signature

Date

Parent/Guardian Name

Parent/Guardian Signature

Date

CHS MEDICAL INSURANCE-ACKNOWLEDGEMENT OF COVERAGE

WARNING: We (parents/legal guardian) realize that there is a risk of being injured and that injury is inherently possible in all sports. We realize the risk of injury may be severe, including fractures, brain injuries, paralysis or even death. Realizing the above, we hereby give our child permission to participate in Athletics at Canton High School. Other co-curricular activities do not carry the same risks, but still are not risk free. We therefore understand and give our permission for our child to participate in the above listed activity(ies).

1. The Canton Area School District (CASD) does not provide insurance or pay for medical services for any student in the district for any reason.
2. Activities listed below are considered higher risk than other types of activities: Because of this higher risk it is the policy of the CASD to require parents or legal guardians to provide medical insurance which will cover in total or partially medical services provided to a student involved in these activities.
3. Activities requiring insurance: (Insurance is for all levels——Junior High, Junior Varsity, Varsity)

Band	Band Front	Baseball	Basketball	Cheerleading
Cross Country	Fitness Room	Football	Majorette	Wrestling
Softball	Sports Manager	Track	Volleyball	

4. Insurance Information Policy No. _____
Insurance Company _____
5. As the parent/legal guardian of the herein named student, I understand I am completely responsible for all the cost of any medical services needed or provide to this student/participant. I have medical coverage with the company stated and I will keep the coverage in force while my son/daughter is participating in the above activity(ies)
Parent/Legal Guardian Signature _____ Date _____
6. As a student participant, I realize that there is a risk of being injured and that injury is inherent in all sports. I realize the risk of injury may be severe, including fractures, brain injuries, paralysis or even death. Realizing the aforementioned, I agree to assume the risk.
Student Signature _____ Date _____

PARENT/LEGAL GUARDIAN

The Canton Athletic/Co-Curricular Code of Conduct was developed in conjunction with a coaching and advisors committee. The Code was also reviewed and approved by the School Board. Revisions will be publicized. Signatures will be required before anyone participates on a team or in an activity. The Code is in force from the beginning of the first day of practice or event until the conclusion and all equipment is returned. Some activities are the entire school year, semester, etc. For the purpose of this Code, activities begin and end according to the coach, advisor, sponsor, or administrator. Students need to be aware of individual activity durations for their chosen activity(ies).