INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION &
RE-CERTIFICATION INFORMATION
Mechanicsburg Area School District Athletic Department

PARENTS AND STUDENT-ATHLETES
IMPORTANT INFORMATION – PLEASE READ CAREFULLY

FALL/WINTER STUDENT-ATHLETES:
Student-athletes who DID NOT participate in a FALL or WINTER Sport must have a pre-participation physical evaluation (Yellow Form – 9 pages) performed prior to the first legal day of SPRING practice which is Monday, March 6th for High School Sports (JV/V Baseball, JV/V Softball, JV/V Boys Lacrosse, JV/V Boys Tennis, V Girls and Boys Track & Field and JV/V Boys Volleyball) and Monday, March 13th for Middle School Sports (Boys and Girls Soccer and Girls Volleyball). This pre-participation physical evaluation CAN NOT be performed EARLIER THAN SIX WEEKS (January 23 for HS/January 30 for MS) prior to the first legal day of practice.

- If you played a school sponsored Fall or Winter sport, or have a pre-participation physical evaluation on file for the 2016-17 school year, you must be RE-CERTIFIED (White Form – 4 pages) by completing the white form to play a spring sport NO EARLIER THAN SIX WEEKS (January 23 for HS/January 30 for MS).

IF COMPLETING THE RECERT FORM:

- If all of your answers are "NO" to the questions on the Supplemental History Form (page 2), sign the form and disregard page 3 and return to the MASH or MMS Athletic Trainers.
- If you answer "YES" to any of the questions on the Supplemental History Form, a physician must complete and sign page 3. If the injury was treated and released to play by the MASD Sports Medicine Staff, page 3 will be completed by the MASD Athletic Team Physicians.
- If you answer "YES" to any of the questions on the Supplemental History Form, a physician must complete and sign page 3. If the injury was treated and released by your own physician, page 3 must be completed and signed by that physician.
- Upon completion, return the form to the MASH or MMS Athletic Trainers.

NO PHYSICALS WILL BE DONE BY THE SCHOOL
FOR SPRING SPORTS

NO STUDENT CAN TRY-OUT FOR ANY INTERSCHOLASTIC TEAM WITHOUT THE PRE-PARTICIPATION PHYSICAL EVALUATION FORM – (GOLDEN ROD) OR THE RE-CERTIFICATION FORM – (WHITE), COMPLETED AND RETURNED TO THE SPORTS MEDICINE STAFF. ALL FORMS MUST HAVE THE PROPER SIGNATURES.

If you have any questions, please contact Sandy Zettlemoyer, Head Athletic Trainer at 691-4548 or email him at szettlemoyer@mbgsd.org. All the forms can be found on the Athletic Department's website, www.gomechanicsburg.com and click on Physical Information on the right side of the page.

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Mechanicsburg Area School District
Athletic Department

Interscholastic Sports Permission RECERTIFICATION Form & Contract for Extra-Curricular Activities

This form MUST be completed and returned to the Athletic Trainers prior to the start of the Winter & Spring sports seasons. Student-Athletes who participate in multiple sports are required to be re-certified prior to each subsequent season of competition during a given school year.

Name: ___________________________________ ID #: ________________ Grade for 2016-17: ______________

Sport: ____

Address: ____

Age: ____ Date of Birth: _________ / _________ / _________

Parent Email Address: ____

Phone: Home: (______) ______ - ________ Work: (______) ______ - ________ Cell: (______) ______ - __________

CIRCLE each year you have participated in this school sponsored sport, include the current year:

7 8 9 10 11 12

CIRCLE the Student's Race/Ethnicity:

American Indian/Alaska Native Asian Black Hawaiian/Pacific Island Hispanic White

Are you a HOMESCHOOL or CYBERSCHOOL student: YES NO

CONFIDENTIALITY STATEMENT

The information in this physical form will be kept confidential and will be used by the athletic administration, coaches and medical staff for identifying injuries and medical conditions as well as to ensure safety and injury prevention. **Additionally, permission is granted to the Athletic Administration and Medical Staff to consult with your physician or other medical specialist, at their discretion, regarding an injury or medical condition.** Information about an injury or medical condition will not be shared with the public or media without the written consent of the parents or guardians.

STUDENT-ATHLETE & PARENT/GUARDIAN SIGNATURES

My signature below acknowledges that I have read and fully understand the contents of this permission form and contract including the **Drug, Alcohol, Tobacco and Steroid Policy, Attendance Policy, Academic Eligibility Policy, Wildcat Code, Good Citizenship, Code of Conduct and Confidentiality Statement and that I will adhere to the expectations set forth.** I have completed all blanks accurately to the best of my knowledge and hereby give consent for__________________ Grade ______ to participate in athletics in the Mechanicsburg Area School District during the current school year.

Student's Signature ____ **Date** _____ / _____ / _____

Parents/Guardian's Signature____ **Date** _____ / _____ / _____

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NON-DISCRIMINATION POLICY

The Mechanicsburg Area School District, an equal opportunity employer, will not discriminate in employment, educational programs or activities based on sex, race, religion, national origin, color or handicap. This policy of non-discrimination extends to all other legally protected classifications. Publication of this policy in this document is in accordance with state and federal laws including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1973, and Section 504 of the Rehabilitation Act of 1973, and the American's With Disabilities Act. Inquiries should be directed to the Compliance Officer, Personnel Coordinator, Mechanicsburg Area School District, 500 South Broad Street, Mechanicsburg, PA 17055-4199

SUPPLEMENTAL HEALTH HISTORY

Explain "YES" answers at the bottom of this form. Circle questions you do not know the answers to.

	YES	NO
1. Since completion of the CIPPE (Physical Form), have you sustained an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic medicine?		
2. Since completion of the CIPPE (Physical Form), have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?		
3. Since completion of the CIPPE (Physical Form), have your experienced dizzy spells, blackouts, and/or unconsciousness?		
4. Since completion of the CIPPE (Physical Form), have you experienced episodes of unexplained shortness of breath, wheezing, and/or chest pain?		
5. Since completion of the CIPPE (Physical Form), 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 here:

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

Student's Signature ____ Date _____ / _____ / _____

Parents/Guardian's Signature____ Date _____ / _____ / _____

THIS PAGE IS ONLY TO BE FILLED OUT IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ON THE PREVIOUS PAGE.

Section 6: CERTIFICATION BY LICENSED PHYSICIAN OF MEDICINE OR OSTEOPATHIC MEDICINE

This Form must be completed for any student who required medical treatment from a licensed physician of medicine or osteopathic medicine. This form may be completed at any time following completion of such medical treatment. Upon completion, the form must be turned in to the Athletic Training Room.

The physician completing this form must first review your original CIPPE, which is on file in the Athletic Training Room. Your physician should also review the previous page of this packet and sign the form below where appropriate.

If the physician completing this Form is clearing the herein named student subsequent to that student sustaining a concussion or head 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 Mechanicsburg High School / Mechanicsburg Middle 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 5 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 5 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__________

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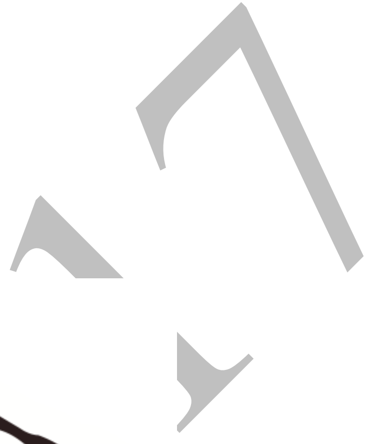
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THIS FORM MUST BE COMPLETED FOR EACH SPORT

MECHANICSBURG AREA SCHOOL DISTRICT
SPORTS MEDICINE DEPARTMENT
500 SOUTH BROAD STREET
MECHANICSBURG, PA 17055-4199
717-691-4548

PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student's Name ______________________________ Age__________ Grade_________

Sport ______________________________

Current Physical Address ______________________________

____

Current Home Telephone #: (_______) _______ - _________ Current Cellular Telephone #: (_______) _______ - _________

Current Work Telephone #: (_______) _______ - _________ Parent Email: ______________________________

EMERGENCY INFORMATION

Emergency Contact Person's Name ______________________________ Relationship ______________________________

Address ______________________________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 Should be Aware______________________________

____

Student's Prescription Medications______________________________

Student's Immunizations (e.g. tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis, pneumococcal; meningococcal; varicella):

☐ Up to date

☐ Not up to date

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