

# Greensburg Central Catholic High School

## Spring 2010 Sports Physicals

All GCC athletes must pass a physical to be eligible for their sport. Please hand in all physicals to the Athletic Trainer by March 1<sup>st</sup>, 2010. Athletes are not permitted to participate in practices or competitions until their physical is turned in.

- Physicals will be held at GCCHS on Wednesday February 24<sup>th</sup>!! There is only one date being offered.
- The physical packet must be completely filled out, signed, and dated by the parent/guardian AND athlete BEFORE arriving for the physical exam.
- Once the physical exam is completed, the athlete will hand it directly to the Athletic Trainer.
  - Females:
    - Softball..... 8am
    - Lacrosse.....8:20am
    - Track & Field.....8:40am
  - Males:
    - Track & Field.....9am
    - Baseball..... 9:20am
    - Lacrosse.....9:40am
    - Tennis.....10am

Each athlete is also required to take a baseline concussion test called ImPACT (Immediate Post-concussion Assessment and Cognitive Testing). A baseline assessment is only required every other year. The testing dates and times will be coordinated by the Athletic Trainer through the coaches for each team (testing is done at GCC).

\*Any questions regarding this info please contact the Athletic Trainer, Amy Eckman, at [eckmana@upmc.edu](mailto:eckmana@upmc.edu)

**SECTION 4: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION  
AND CERTIFICATION OF PHYSICIAN**

Must be completed and signed by the licensed physician of medicine or osteopathic medicine performing the herein named student's comprehensive initial pre-participation physical evaluation.

Student's Name \_\_\_\_\_ Age \_\_\_\_\_

Enrolled in \_\_\_\_\_ School Sport(s) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ )

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		
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 and further certify that the student does not have any communicable illness or condition, which would pose a danger to teammates and/or competitors:

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) \_\_\_\_\_

Physician's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ MD or DO (circle one) Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION**

Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or contests, at any PIAA member school, the student is required to complete a physical evaluation. A student completing a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE) need not have a re-certification for a period of twelve (12) months, unless the student suffers a serious illness or injury within those twelve (12) months.

Students seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or contests through the CIPPE must have the appropriate person(s) complete the first four Sections of this form (Sections 5 and 6 should be completed only if a re-certification becomes necessary). Upon completion of Sections 1 and 2 by the parent/guardian, and Section 4 by a licensed physician of medicine or osteopathic medicine, those Sections must be turned in to the student's school for retention by the school. Upon completion, section 3 may be retained by the student and/or the student's physician.

**Section 1: Personal and Emergency Information**

**PERSONAL INFORMATION**

ATHLETE'S NAME \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ GRADE: \_\_\_\_\_ SEX: \_\_\_\_\_

PARENTS (GUARDIAN) NAME: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE MOM: \_\_\_\_\_ CELL MOM: \_\_\_\_\_

WORK PHONE DAD: \_\_\_\_\_ CELL DAD: \_\_\_\_\_

IN THE EVENT PARENTS CANNOT BE CONTACTED, PLEASE CONTACT:

\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE \_\_\_\_\_

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

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Family Physican's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Student's Health Condition(s) of Which an Emergency Physician Should be Aware \_\_\_\_\_

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

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 ( see attached documentation)

Not up to date Specify \_\_\_\_\_

**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.

Sport	Signature of Parent or Guardian
Baseball (Spring)	
Basketball (Winter)	
Bowling (Winter)	
Cross Country (Fall)	
Field Hockey (Fall)	
Football (Fall)	
Golf (Fall)	
Gymnastics (Winter)	
Lacrosse-Girls (Spring)	
Rifle (Winter)	
Soccer (Fall)	
Soccer-Girls (Spring)	
Softball (Spring)	
Swimming & Diving	
Tennis-Girls (Fall)	
Tennis-Boys (Spring)	
Track-Indoor (Winter)	
Track & Field (Spring)	
Volleyball-Girls (Fall)	
Volleyball-Boys (Spring)	
Water Polo (Fall)	
Wrestling (Winter)	

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 or Scrimmages and Contests involving PIAA member schools. Such requirements 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 reports of Inter-School Practices or Scrimmages and 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 a licensed physician of medicine or osteopathic medicine 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 or Scrimmages and 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 assume and agree to pay indebtedness or physicians' and surgeons' fees and hospital charges for such emergency medical care.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION 3: 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 sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>				
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<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"/>				
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<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"/>				
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>				
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>				
6. Have you ever passed out or nearly passed out AFTER 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"/>				
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>				
8. Does your heart race or skip beats 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"/>				
9. Has a doctor ever told you that you have (check all that apply):			30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/> High blood pressure			31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/> Heart murmur			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/> High cholesterol			33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/> Heart infection			34. Do you have headaches with exercise?	<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"/>	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"/>				
11. Has anyone in your family died for no apparent reason?	<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"/>				
12. Does anyone in your family have a heart problem?	<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"/>				
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<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"/>				
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>				
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>				
16. Have you ever had surgery?	<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"/>				
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or contest? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you happy with your weight?	<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"/>	43. Are you trying to gain or lose weight?	<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"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>				
Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/Fingers	Chest		
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/Toes		
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	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"/>	
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"/>	<b>FEMALES ONLY</b>				47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
			48. How old were you when you had your first menstrual period?				49. How many periods have you had in the last 12 months?	_____	_____
			49. How many periods have you had in the last 12 months?				50. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

No(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 \_\_\_\_/\_\_\_\_/\_\_\_\_



**UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)  
CONSENT FOR TREATMENT AND HEALTH CARE OPERATIONS (TPO)**

I \_\_\_\_\_ (print or type name) 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/school/family physician, school nurse, and licensed physical therapists. Also, under the direction of a certified athletic trainer may include college/university student athletic trainers, and high school student athletic trainers.

_____ Athlete/patient signature	_____ Date	_____ UPMC Sports Medicine representative
_____ Parent / Guardian Signature	_____ Date	_____ UPMC Sports Medicine representative
_____ Signature/identify on behalf of patient/relationship	_____ Date	_____ UPMC Sports Medicine representative



**UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)  
Authorization for Release of protected Health Information**

**RELEASE OF PROTECTED HEALTH INFORMATION**

- I authorize UPMC to provide information related to my care to be provided to the family/school/team physician, school nurse, coaches, athletic directors, school principals, EMS personnel, and such persons as needed for them to provide consultation, treatment, and establish a plan of care.
- I give authorization to UPMC to use my UPMC billing information for UPMC departmental internal reporting only.
- I give authorization to UPMC (including hospitals, other entities and programs) to access medical or other information maintained on electronic information systems or stored in various forms at individual UPMC affiliates related to treatment/or services provided to me by UPMC and/or any affiliate in connection with my care, health care operations, or payment for treatment and services. I also authorize information related to my care to be provided to my family/team/school physician and such persons as necessary for them to provide consultation, treatment, and/or services to me.
- I understand that my health record(s) will not be released or obtained by UPMC unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information (Authorization)
- I understand that the release of my health record(s) will be for the purpose stated on this form.
- I understand that the health record(s) released by UPMC may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) UPMC and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- I understand that this Authorization is in effect for a period of the current scholastic sport season (fall, winter, or spring as designated by the school), or beyond in the event of the continued treatment of an injury from that designated sports season; however, no time frame specified shall go beyond one year from the date of signature.
- I understand that this Authorization is also in effect if I am 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 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.

_____ Athlete/patient signature	_____ Date	_____ UPMC Sports Medicine representative
_____ Parent / Guardian Signature	_____ Date	_____ UPMC Sports Medicine representative
_____ Signature/identify on behalf of patient/relationship	_____ Date	_____ UPMC Sports Medicine representative

<b>Name:</b>	<b>Date of Birth:</b>
<b>Address:</b>	<b>SS #:</b>
	<b>EMERGENCY INFORMATION</b>
<b>Home Phone #:</b>	<b>Allergies:</b>
<b>Father's Work #:</b>	
<b>Mother's Work #:</b>	<b>Medications:</b>
<b>Emergency Contacts:</b>	
<b>Primary Physician:</b>	

## INSURANCE INFORMATION

**Company:**

**Policy #:**

# Greensburg Central Catholic High School

• Founded by Bishop Hugh L. Lamb, 1959 •



Greensburg Central Catholic High School

Injury Risk / Emergency Consent / Athletic Permit Contract

**Section 1: Parent / Guardian Permit:** I hereby give my consent for the above named to participate in said sport at Greensburg Central Catholic High School, and give my permission for him / her to participate in any travel associated with the sport as authorized by the school.

**Section 2: Insurance Waiver and Release from Liability:** We, the undersigned parents / guardians agree that Greensburg Central Catholic High School and the employees of Greensburg Central Catholic High School shall be in no way responsible for any injuries suffered by him / her while engaged in any interscholastic sports sponsored by Greensburg Central Catholic High School. Further, we hereby release the aforesaid of and from any liability for such injuries. This action is being taken in view of the fact the he / she is covered by the insurance on page 7 of this document.

**Section 3: Injury Risk:** Every participant should be aware that there are certain risks associated with any sporting activity, and that personal injury may result in any interscholastic sport. There is an increased danger in any interscholastic sport which entails body contact as integral part of the sporting activity or as a possible consequence. Such body contact sports include, but are not limited to football, basketball, wrestling, baseball and lacrosse. The undersigned and his / her parent / guardian(s) acknowledge that such risks exists, and by their signature hereto indicate their willingness to voluntary participate in the sporting activity with full knowledge of possible risk including bodily injury.

**Section 4: Emergency Consent:** In case of an emergency, I give my permission to the hospital or physician to perform or administer emergency care and treatment to my son / daughter.

**By providing your signature(s) below you are agreeing to all four sections above:**

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

Athlete's Signature: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_