

Downingtown Area School District Department of Athletics

Interscholastic Sports Information Packet

As governed by the PIAA Constitution & By-Laws, no student shall be eligible to represent the student's school in an Inter-School Practice, Scrimmage, or Contest unless the student has participated in a pre-participation physical evaluation. The pre-participation physical evaluation for **fall sports** shall not be performed earlier than **June 1**. The evaluation, reevaluation, or certification for **all other sports shall not be performed earlier than six weeks prior** to the first Practice day for each applicable sport.

Official practice start dates for the 2007-2008 school year:
Fall – August 13 Winter – November 12 Spring – March 3

We, _____ and _____
(student's name) (parent/guardian name)

1. We acknowledge that we have received, completed, SIGNED and returned to the coach the following documents:

- Medical Consent Form
- Accident insurance
- Parent's/Physician's Certificate (including doctor's signature)
- Pre-participation Physical Evaluation (including doctor's signature)
- Athlete Information Sheet

2. We acknowledge that we have read and understand the following documents:

- Co-Curricular Code of Conduct
- Addendum A – PIAA DASD Athletic Program Requirements
- Anabolic Steroids
- Attendance Procedures
- Equipment

3. We acknowledge and understand that participation in co-curricular activities is a privilege that may be suspended or revoked if the student violates the rules and regulations on and off school premises during the season.

Signature of Student

Signature of Parent or Guardian

Sport _____

Date _____

DOWNINGTOWN AREA SCHOOLS
MEDICAL CONSENT FORM

ATHLETE: _____

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, X-ray examinations and immunizations for the above-named student. In the event of serious illness, the need for major surgery or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

In the event that an emergency arises during a practice session, an effort will be made to contact the parents or guardians as soon as possible. Permission is also granted to the athletic trainer to provide the needed emergency treatment of the athlete prior to his admission to the medical facilities.

SIGNATURE OF PARENT/GUARDIAN

DATE

Phone numbers where parents can be reached:

Office: _____

Home: _____

Other: _____

Name of Family Physician: _____

Physician Phone Number: _____

Hospital Preference: _____

Emergency contact if parent cannot be reached:

Name

Phone

Medic-Alert History: _____

Insurance Carrier: _____

Insurance Number: _____

DOWNINGTOWN AREA SCHOOL DISTRICT

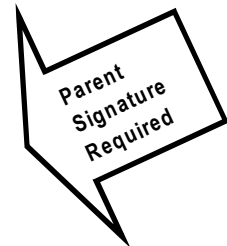
General Instructions for Completing Participation Parent/Doctor Form

1. **PARENT'S CERTIFICATE** – Parents must authorize their son's/daughter's participation by signing opposite the sport at the beginning of each sport season.
2. **PHYSICIAN'S CERTIFICATE** – Each child is required by the P.I.A.A. to have a physical examination or re-examination prior to each sports season. Please sign opposite the individual sport. Wrestlers may be certified at any given weight. They may actually wrestle only at the classification for which they qualify on the day of the meet, plus one class higher. In no way may one wrestle lower than his certified weight. Certified at 98 and weighing 108 on the day of the first meet, a wrestler may compete at 112 or 119. A two (2)-pound growth allowance is authorized on or after January 15th for both junior high/middle school and senior high school wrestlers. Weight classes are as follows:

JUNIOR HIGH: 75, 80, 85, 90, 95, 100, 105, 110, 115, 122, 130, 138, 145, 155, 165, 185, 210, 250

SENIOR HIGH: 103, 112, 119, 125, 130, 135, 140, 145, 152, 160, 171, 189, 215, 275

3. Insurance: You may wish to purchase the school insurance offered at the beginning of each school year or you may wish to cover any unforeseen medical expenses brought on by sports participation through your personal medical insurance. Please complete the appropriate insurance information below.



ACCIDENT INSURANCE

SCHOOL BOARD POLICY requires insurance coverage for the activities, and a statement must be kept on file regarding this. Please sign the appropriate statement below regarding insurance.

I HAVE SCHOOL INSURANCE, which covers my son/daughter in athletics:

Signature of Parent/Guardian

Date

I HAVE OUR OWN FAMILY INSURANCE covering any of my son's or daughter's accidents during sports activity and I assume all responsibility and waive all claims against the Downingtown Area School District for any injury which my son/daughter may receive as a result of participation in the interscholastic athletic program at the Downingtown Area School District.

Signature of Parent/Guardian

Date

NAME _____

SCHOOL _____

SPORT _____

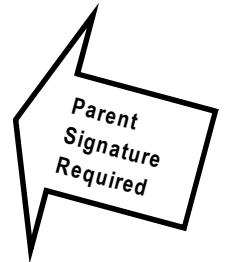
GRADE _____ DATE _____

I. PARENT'S CERTIFICATE

In accordance with the purpose and spirit of P.I.A.A. By-Laws, Article IV, Section I, printed below, I give my consent for the above named pupil to take part in athletic contests during the school year 20____ - 20____ in the sport or sports **AS INDICATED BY MY SIGNATURE following the name of the said sport or sports** approved below.

Cross Country _____
Football _____
Field Hockey _____
Golf _____
Soccer _____
Tennis _____
Volleyball _____
Cheerleading _____

Wrestling _____
Basketball _____
Indoor Track _____
Swimming _____
Baseball _____
Softball _____
Lacrosse _____
Spring Track _____



BY-LAWS: Article IV - Section I

CONSENT OF PARENT IS NECESSARY BEFORE PUPIL STARTS PRACTICE.

A pupil shall be eligible for practice or participation in each sport only when there is on file with the principal a certificate of consent, which is signed by his/her parent/guardian.

II. PHYSICIAN'S CERTIFICATE

I have examined the general physical condition of the above mentioned pupil and find him/her to be physically fit to participate in athletic contests with members of junior high school and senior high school sports teams as indicated by the date of the examination and by my signature.

	DATE OF EXAMINATION	PHYSICIAN'S SIGNATURE—M.D., D.O.
Cross Country	_____	_____
Football	_____	_____
Field Hockey	_____	_____
Golf	_____	_____
Soccer	_____	_____
Volleyball	_____	_____
Cheerleading	_____	_____
Basketball	_____	_____
Indoor Track	_____	_____
Wrestling	_____	_____
Swimming	_____	_____
Baseball	_____	_____
Softball	_____	_____
Lacrosse	_____	_____
Tennis	_____	_____
Track	_____	_____

Minimum Weight Class at which pupil may wrestle during current year:
_____ Lbs. _____

(See previous page for actual weight classes)

Pre-Participation Physical Evaluation

PHYSICAL EXAMINATION

Name _____	Date of Birth _____
Height _____	Weight _____ % Body Fat (optional) _____
Pulse _____	BP _____ / _____ (_____ / _____, _____ / _____)
Vision R 20/ _____ L 20/ _____	Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<u>MEDICAL</u>			
Appearance			
Eyes/Ears/Nose Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<u>MUSCULOSKELETAL</u>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station based examination only

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not Cleared for: _____ Reason: _____

Recommendations: _____

Name of Physician (please print) _____

Address _____ Telephone _____

Signature of Physician _____ MD or DO

Pre-Participation Physical Evaluation

HISTORY

DATE OF EXAM _____

Name _____	Sex _____	Age _____	Date of Birth _____
Grade _____	School _____	Sport(s) _____	
Address _____			
Personal Physician _____			
<i>In Case of Emergency, Contact – Name</i> _____			
Relationship _____		Telephone (H) _____	(W) _____

Explain "Yes" answers below. Circle questions you don't know the answers to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical? Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you have any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you even been hospitalized over night? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any problems with your eyes or vision? Do you wear glasses, contact, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or Nonprescription (over-the-counter) medications or pills or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain, or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? <i>If yes, check appropriate box and explain below.</i>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Knee <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Shin/calf <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Ankle <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Upper Arm <input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise? Have you ever been dizzy during exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Have you had a severe viral infection (for example, myocarditis or mononucleosis)? Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Do you have frequent or severe headaches? Have you ever had a seizure? Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	15. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____		
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY		
9. Do you cough, wheeze or have trouble breathing during or after activity? Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	16. When was your first menstrual period? _____ When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another? _____ How many periods have you had in the last year? _____ What was the longest time between periods in the last year? _____ Explain "Yes" answers here: _____ _____ _____ _____ _____		



I herby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete	Signature of Parent/Guardian
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**Downingtown Sports Medicine
Athlete Information Sheet**

This information will be used for computerized record keeping in the athletic training room and should be completed thoroughly. PLEASE PRINT

Student Information:

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Home Phone: _____

Sport: _____
School: _____
Grade: _____
Gender: _____
Birth Date: _____
(Month / Day / Year)

Emergency Contacts:

Parent/Guardian

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Home Phone: _____
Work Phone: _____

Relation: _____
(Mother / Father / Etc.)

If parent/guardian cannot be reached:

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Home Phone: _____
Work Phone: _____

Relation: _____
(Grandparent / Friend / Etc.)

Medical Information:

Family Doctor: _____
Phone: _____
Orthopedic Doctor: _____
Phone: _____
Medical Alerts (If any) _____

Insurance Information:

Company: _____
Plan Number: _____
Policy Number: _____