



RECERTIFICATION PHYSICAL=RP
Jersey Shore Area Middle and Senior High School
Student-Athletic Contract

Print
Except Signatures

Name _____ Date of Birth _____ Age _____

Address _____

Name of Sport _____ Grade _____ (when sport will be played)

Grades of Participation: 7 8 9 10 11 12 (circle years played) Phone Number _____

Article IV-Section 1. Consent of Parent Necessary before Pupil Starts Practice. A pupil shall be eligible for practice or participation in each sport ONLY when there is a file with the principal, a certificate of consent which is signed by his/her parent(s) or guardian(s). The only valid certificate of consent is the P.I.A.A. Parent's Certificate.

Parent's Certification

I hereby acknowledge that I am familiar with the requirements of P.I.A.A. concerning the eligibility of a student at P.I.A.A. member schools to participate in interscholastic athletic contests involving P.I.A.A. 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.

I hereby certify that the above named pupil has been informed by the principal, athletic director or the coach concerning P.I.A.A.'s Season and Out-of-Season Rules and Regulations as they apply to the involved sport.

I hereby consent to the release of P.I.A.A. of any portions of school record files, beginning with the seventh grade, of the above named pupil necessary to enable P.I.A.A. to determine whether the above-named pupil is eligible to participate in interscholastic athletics involving P.I.A.A. member schools, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent or guardian, residence address of pupil; academic work completed, grades received and attendance data.

Parent/Legal Guardian Signature

Scholastic Certification

The student named above is scholastically eligible to participate in the above named activity.

Principal's Signature

Date

These forms were revised in August 2012 and replace all other forms on this subject.

General Training Rules and Regulations - Athletes

- 1. Will not use tobacco, drugs and/or alcohol or be in possession of the above in any manner or form. Will follow Police #222, Smoking-Tobacco Use - Student Policy #227, Drugs - Alcohol and Administrative Guidelines. Violation school policy may cause removal from all activities for a period of 60 school days from the date of the infraction.
2. Will follow all rules of my coach and the Jersey Shore School District's General Rules for Athletes and Cheerleaders.
3. Must fulfill academic requirements of the school and the P.I.A.A.
4. Accept the decisions of all game and event officials without question.
5. Conduct myself at other schools that I bring credit to my school, my team, my coach, and myself.
6. Refrain from playing with teams outside the jurisdiction of the Jersey Shore School District during the season unless given permission by the coach and principal of the school.
7. Be present at all meetings, practices, and games unless excused by the coach or advisor.
8. I agree to be responsible for any and all equipment that is issued to me by the school district. Furthermore, I agree to use issued equipment for practice sessions or official contests and that any equipment not returned within two weeks after the end of my formal participation, I will pay for the replacement of the item. Failure to return equipment or money may result in this matter being given to a Lycoming County District Magistrate for collection.
9. I will obey all training rules and regulations of the school and those set by my coach or advisor. I know that failure to follow the rules could result in loss of game time, suspension for a period of time, or complete removal from the team or removal for 60 days from all activities.
10. If my son/daughter is reasonably suspected by a school employee of having a drug and/or alcohol problem, I give my permission to the school to have him/her tested at the district's expense. YES [] NO []

Athlete's Signature

Date

Parent/Guardian Signature

Date

SECTION 7: 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 8, 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 Sports(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 for in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Parent/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 #() _____

SUPPLEMENTAL HEALTH HISTORY:

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

- | | | | |
|--|---------------|--|---------------|
| <p>1. Since completion of the CIPPE, have you sustained an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic medicine?</p> <p>2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?</p> <p>3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?</p> | <p>Yes No</p> | <p>4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?</p> <p>5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills?</p> <p>6. Do you have any concerns that you would like to discuss with a physician?</p> | <p>Yes No</p> |
|--|---------------|--|---------------|

#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/Guardian's Signature _____ Date ___/___/___

SECTION 8: RE-CERTIFICATION BY LICENSED PHYSICIAN OF MEDICINE OR OSTEOPATHIC MEDICINE

This form must be completed for any student who, subsequent to completion of Section 1 through 6 of the CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. The Section 8 may be completed at any time following the 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 not is employed, by another licensed physician of medicine or osteopathic medicine."

NOTE: The physician completing this Form must first review Sections 5 and 6 of the herein named Student's previously completed CIPPE Form. Section 7 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 7.

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

Student's Name: _____ Age _____ Grade _____

Enrolled in _____ School _____

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

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

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

Address _____ Phone () _____

Physician's Signature _____ MD or DO (circle one) Date _____

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