



Hanover Area School District

1600 Sans Souci Parkway

Hanover Township, Pennsylvania 18706-6091

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ATHLETIC INJURIES 2010-2011 SCHOOL YEAR

Dear Parents/Guardians:

The Hanover Area School District does not endorse or recommend any Medical Facility or Treatment Center in the treatment of its students who have been injured during Athletic Events or other Extra-Curricular Activities. In case of a non-emergency, the parents/guardians must have the injured student treated at a facility which is covered by their Medical Insurance, for example, if you have HMO Insurance Coverage, you must go to your HMO hospital for treatment. In the case of an emergency, the injured student should be taken to the closest available Medical Facility for initial treatment.

Attached is a listing of steps that must be followed for insurance when a student is injured.

Sincerely,

Thomas R. Cipriano, Jr.
Business Administrator

TRC/cts

Attachments

CC: Mr. Anthony Podczasy, Superintendent
Mr. David Fisher, Junior/Senior High School Principal
Mr. Russell Davis, Athletic Director
All Coaches
All Activity Directors

HANOVER JR/SR
HIGH SCHOOL
831-2300

MEMORIAL
ELEMENTARY
822-5102

LYNDWOOD
ELEMENTARY
824-3732

HANOVER GREEN
ELEMENTARY
824-3941

LEE PARK
ELEMENTARY
824-4741

HANOVER AREA SCHOOL DISTRICT
IMPORTANT INSURANCE INFORMATION

If your child is injured while playing Sports or in a school related Extra Curricular Activity, you must follow the Steps below in order for your medical bills to be paid promptly:

STEP #1 All injuries must be reported immediately to the Coach, Activity Director, Athletic Trainer or the Athletic Director listed below:

MR. RUSSELL DAVIS, ATHLETIC DIRECTOR
HANOVER AREA SCHOOL DISTRICT
1600 SANS SOUCI PARKWAY
HANOVER TOWNSHIP, PA 18706-6091

TELEPHONE # (570) 831-2304
FAX # (570) 831-2311

STEP #2 After the School District Insurance pays the first \$100.00 for Usual and Customary Services, you will receive a notification from Peoples Benefit Life Insurance Company through Bollinger, Inc. that it has paid the first \$100.00. Once this occurs, send the notification from Peoples Benefit Life Insurance Company, that they paid the first \$100.00 along with any remaining or subsequent bills for Usual and Customary Services to your Insurance Company (HMO, PPO, etc.).

STEP #3 All Usual and Customary Services provided that is not covered by your Insurance Company, should be submitted to the School District Insurance Company.

<p><u>NOTE:</u> The only services that will be covered by any Insurance Carrier must be considered Usual and Customary. Any services requested by parents that are not considered Usual and Customary will be done at the parent's expense.</p>

HANOVER AREA SCHOOL DISTRICT

T O: Parents of Hanover Area School District Athletes
F R O M: Thomas R. Cipriano, Business Administrator
R E: Sports Accident Insurance Procedures
D A T E: 2010-2011 School Year

The Hanover Area School District will supply all participants of school related sports activities with insurance provided by Peoples Benefit Life Insurance Company through Bollinger, Incorporated.

In the event of any injury, the following procedures must be followed:

HANOVER AREA SCHOOL DISTRICT
2010-2011 SCHOOL YEAR

SPORTS/STUDENT ACCIDENT INSURANCE PROCEDURES

1. The Coach, Athletic Trainer, or Activity Director must complete a Student Accident Claim Form upon notification of an injury, then submit the Student Accident Claim Form to the Athletic Director.
2. The Athletic Director must verify all the information on the Student Accident Claim Form, then sign the School District's portion of the Claim Form.
3. The Athletic Director will mail the Student Accident Claim Form, within 48 hours of injury, to the School District's Insurance Company:

***Frank P. Crossin Agency, Inc.
(Agent for Hanover Area School District)
Attention: Kathleen Gillette
575 Pierce Street, Suite 302
Kingston, PA 18704***

(570) 822-5111 or FAX (570) 824-8825

4. Frank P. Crossin Agency, Inc., will then forward the Student Accident Claim Form to the Parents/Guardians with instructions for completing the form and processing the claim. All bills related to the injury are to be sent with the Student Accident Claim Form.

A self-addressed stamped envelope will be provided to return the completed Claim Form to Frank P. Crossin Agency, Inc.

If you have any questions with the Claim Form, please call:

**KATHLEEN GILLETTE
FRANK P. CROSSIN AGENCY, INC.
(Agent for Hanover Area School District)
575 PIERCE STREET, SUITE 302
KINGSTON, PA 18704**

(570) 822-5111 or FAX (570) 824-8825

5. The Athletic Insurance provided is Secondary Coverage, not Primary coverage. This means that all claims must be first submitted to your own personal insurance carrier. The Secondary Insurance will cover the first \$100.00 of claims incurred regardless if you have insurance or not. If you have insurance, any procedures submitted for payment to your own insurance carrier which are approved and not paid for in full, are to be submitted to A.J. Lupas Insurance Agency, Inc. for processing. This includes, but is not limited to deductibles, coinsurance, office visits, etc. If you have no personal insurance, then the Secondary Coverage provided by Peoples Benefit Life Insurance Company through Bollinger, Inc., will then become the injured's Primary Coverage. In this case, all claims incurred must be submitted to Frank P. Crossin Agency, Inc., for processing.

**IT IS EXTREMELY IMPORTANT THAT ALL STEPS ARE
COMPLETED AS PROMPTLY AS POSSIBLE.**

COACHES

PLEASE BE AWARE OF THE FOLLOWING

District Policies:

1. Absence from school for the entire day, or any part of the day, without prior consent by the principal renders the athlete ineligible for games or practices that day. Friday absence means the athlete is ineligible for Saturday.
2. Any student determined to be under the influence of drugs or alcohol while on school property receives a mandatory ten (10) day suspension and mandatory counseling at a drug rehabilitation center.
3. No coaches or athletes may use the swimming pool.
4. No students or athletes are permitted in the building without proper supervision.
5. Indoor practices must coincide with custodial hours.

STATE REGULATIONS WORTH NOTING:

All sports are confined to their particular seasons mandated by the P.I.A.A.

The P.I.A.A. has no rules or authority to govern conditioning, therefore, conditioning can take place at anytime during the school year. Coaches should be present at and control their respective conditioning program. Conditioning can take place at anytime of the year.

ELIGIBILITY:

1. Age: Junior High – A student in the ninth (9) grade who turns sixteen (16) on or after August 1st is eligible for Junior High participation.
2. A student remains eligible for senior high activities up to the age of nineteen (19), if he turns nineteen on or after August 1st.
3. Academics: Minimum standard is the passing of a total of four (4) credits in the semester previous to the one in which he/she is participating in an activity. Fall semester eligibility will be determined by the previous year's grades and credits.
4. Attendance: All students, in order to be eligible for activities, must not miss twenty (20) or more days of absence in the previous semester. Penalty is the student is ineligible for all activities and practices for sixty (60) semester days following his twentieth day of absence. All additional days missed from the twentieth (20th) day up to the present are not counted as part of the sixty (60) days.
5. Parental consent forms are necessary for each participant and each sport he/she participates in as is a physical examination.

PERIOD OF PARTICIPATION:

1. Each senior high participant can play three (3) seasons per activity, (i.e., three (3) years of baseball and three (3) years of golf, etc.)
2. Each junior high participant can play three (3) seasons per activity assuming the junior high includes 7, 8, and 9th grades. He can, however, participate only once per grade per sport. For instance, a boy plays basketball in ninth grade, he fails ninth grade, he cannot participate in basketball again in ninth grade on the junior high level.
3. A pupil is considered as participating only if he has played in a game.
4. Pupils can participate for eight (8) semesters past eighth grade. Waiver can be obtained for illness, etc.

PENALTIES:

1. For all state regulations, penalties range from expulsion to suspension, down to forfeiture of championships and forfeiture of games.
2. District regulation penalties will be determined by the principal and athletic director.

HANOVER AREA SCHOOL DISTRICT

ATHLETIC INJURY ACTION PLAN

TO BE FOLLOWED BY ALL COACHES/ATHLETES/PARENTS:

I. When an athlete is injured during practice or home game:

- A. Coach or Athletic Training Student contacts Head Athletic Trainer
- B. Head Athletic Trainer evaluates athlete and determines appropriate course of action.

II. When an athlete is injured at an away game:

- A. Athletic Trainer from Host School will evaluate, if available.
- B. If Athletic Trainer is not available, coach will determine appropriate action.
- C. Upon return to Hanover Area, Coach/injured athlete will meet with Head Athletic Trainer for evaluation. The appropriate course of action will be determined at this time.
- D. If injury sustained by the athlete is determined to be an emergency, coach will call an ambulance. The injured athlete will bring ER report to Head Athletic Trainer upon his/her return to Hanover Area.

III. If injury is an immediate emergency:

- A. Coach/Athletic Training Student will call for ambulance/911
- B. Head Athletic Trainer will then be contacted.
- C. The injured athlete will bring ER report to Head Athletic Trainer upon return to Hanover Area.

IV. If doctor's referral is needed:

- A. Head Athletic Trainer will complete referral form.
- B. Referral form will be sent with injured athlete.
- C. Referral form will be completed by doctor.
- D. Athlete will return referral form to Head Athletic Trainer upon his/her return to Hanover Area.

HANOVER AREA SCHOOL DISTRICT
ATHLETIC AND EXTRA CURRICULAR ACTIVITIES

NAME OF STUDENT: _____

ADDRESS OF STUDENT: _____

GRADE: _____ SCHOOL SPORT/ACTIVITY: _____

NAME OF INSURED: _____

ADDRESS OF INSURED (if different from above):

DAY TIME TELEPHONE NUMBER: (_____) _____

NIGHT TIME TELEPHONE NUMBER: (_____) _____

SOCIAL SECURITY NUMBER OF INSURED: _____

NAME AND TYPE OF MEDICAL INSURANCE: (For example: HMO, PPO
Medical Insurance, etc.)

AGREEMENT NUMBER: _____

GROUP NUMBER: _____

PLAN CODE: _____

SIGNATURE OF INSURED: _____

DATE: _____

**PLEASE RETURN COMPLETED FORM TO YOUR COACH OR ACTIVITY
DIRECTOR AS SOON AS POSSIBLE.**

NAME _____

GRADE _____

SPORTS _____

PIAA ATHLETIC PHYSICAL FORMS

THERE ARE (6) PAGES IN THIS PACKET:

- . Section 1: Personal and Emergency Information
- . Section 2: Certification of Parent/Guardian
- . Section 3: Health History
- . Section 4: PIAA Comprehensive Physical Evaluation
- . 5 & 6. UPMC Consent to Treat and HIPAA Forms
(Shaler Area contracts for athletic training services through UPMC Sports Medicine, these forms are required by the athletic training staff.)

SECTIONS 1,2 AND 3 AND THE UPMC FORMS MUST BE COMPLETED AND SIGNED BY PARENT AND ATHLETES BEFORE OBTAINING THE PHYSICAL.

PHYSICALS MUST BE OBTAINED AFTER JUNE 1ST TO APPLY TO THE NEXT SCHOOL YEAR.

THESE FORMS MUST BE TURNED INTO THE ATHLETIC OFFICE PRIOR TO THE START OF YOUR SEASON.

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 four Sections of the CIPPE Form. Upon completion of Sections 1, 2, and 3 by the parent/guardian, and Section 4 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 performed earlier than June 1st and shall be effective, regardless of when performed during a school year, until the next May 31st.

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 5 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 6 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 # () _____

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 Should be Aware _____

Student's Prescription Medications _____

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	
Girls' Gymnastics	
Rifle	
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Lacrosse	
Girls' Soccer	
Softball	
Boys' Tennis	
Track & Field	
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 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.

Parent's/Guardian's Signature _____ Date ____/____/____

F. Understanding of risk of concussion and head injury: I hereby acknowledge that I am familiar with the nature and risk of concussion and head injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or head injury. Information relevant to concussion in high school sports is available on the PIAA Web site at www.piaa.org/piaa-for/sports-med.

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 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 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 HEAD INJURY			
	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur			31.	Have you ever had a concussion (i.e. bell rung, ding, head rush) or head injury?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			32.	Have you been hit in the head and been confused or lost your memory?	<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"/>	33.	Do you experience dizziness and/or headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34.	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Does anyone in your family have a heart problem?	<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"/>
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	<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"/>
14.	Does anyone in your family have Marfan syndrome?	<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"/>
15.	Have you ever spent the night in a hospital?	<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"/>
16.	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39.	Have you had any problems with your eyes or vision?	<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:			40.	Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
	Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest			41.	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:			42.	Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
	Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes			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:			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			45.	Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
	Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes			46.	Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY			
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"/>	47.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
22.	Do you regularly use a brace or assistive device?	<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"/>

#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 4: 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) _____ BP _____/_____/_____ (_____/_____, ____/____) RP _____

If either the 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		
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) Date of CIPPE ____/____/____

SECTION 5: 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 6, 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 _____

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.

- | | Yes | No | | Yes | No |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 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? | <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"/> |
| 2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 5. Since completion of the CIPPE, are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? | <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 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 6: 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 4 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 6 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.

NOTE: The physician completing this Form must first review Sections 3 and 4 of the herein named student's previously completed CIPPE Form. Section 5 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 5.

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 _____ 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 4 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 4 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 7: 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.

**TO: Mr. Thomas R. Cipriano
Business Administrator
Hanover Area High School**

DATE: July 1, 2010

**FROM: Jamie Shea
Manager
Geisinger Wyoming Valley**

RE: HIPPA Authorization

Attached you will find a HIPPA Authorization to Request Medical Information form.

The athlete should fill out the medical information form and copies should be given to the athletic trainer and the coach of that particular sport. It is very important that the coach has this form in the event that an injury occurs while participating at an away event.

In the past, I have handed this form out at the beginning of each season with repercussions of being unable to participate until the form was returned. Henceforth, it was successful.

If you have any questions please contact me at 820-6086.

**HANOVER AREA SCHOOL DISTRICT
ACKNOWLEDGEMENT OF PARENTS**

2010-2011 SCHOOL YEAR

I hereby certify that I have read and understand the information available for Sports/Interscholastic Insurance.

Name of Participant: _____

School Sport/Activity: _____

Signature of Parents: _____

Date: _____

**PLEASE RETURN COMPLETED FORM TO YOUR COACH OR
ACTIVITY DIRECTOR AS SOON AS POSSIBLE.**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____
 Address: _____
 Address: _____
 Birthdate: _____
 Medical Record No.: _____

GEISINGER EMPLOYEE USE ONLY

- Geisinger Medical Center
 100 N. Academy Avenue
 Danville, PA 17822
- Geisinger Wyoming Valley Medical Center
 1000 E. Mountain Boulevard
 Wilkes-Barre, PA 18711
- Geisinger Clinic (GMG)

(AS APPLICABLE)

(Specify site and address)

I authorize an appropriate workforce member of the above entity(ies) to release information from my medical record to: Officials of the school that I (Student Athlete) attend. This would include, the coaching staff, athletic directors, insurance carriers and health-care professionals who are involved with my participation in interscholastic athletics.

HANOVER AREA JUNIOR/SENIOR HIGH SCHOOL

(Address and Phone number of receiving party)

for the purpose of: continuation of medical treatment payment of bill Worker's Compensation
 education legal purposes insurance purposes at the request of the patient or the patient's legal representative for personal access or other (specify): _____

The information to be released will cover the time period from 06/01/08 to 06/01/09

SPECIFIC INFORMATION TO RELEASE:

- | | | | |
|-------------------------------------------------|---------------------------------------------|-------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Report(s) | <input type="checkbox"/> Operation Report(s) |
| <input type="checkbox"/> Catheterization Report | <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> Emergency Room Notes | <input type="checkbox"/> Laboratory Report(s) |
| <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> X-ray Report(s) | <input type="checkbox"/> X-ray Film(s) | <input type="checkbox"/> Itemized Bill(s) |

Other (specify) :All information concerning my health that impacts my ability to participate in interscholastic athletics.
 This may include information about injuries (such as sprains), surgeries, or medical conditions (such as asthma). This is to inform the above referenced people of my health -related limitations and abilities to continue to participate in interscholastic athletics.

Other (specify) : To provide the above referenced people with information on how to help me safely participate in interscholastic athletics

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact the above entity(ies) immediately if I wish to revoke this authorization. As described in the Notice of Privacy Practices for the above entity(ies), I may request such Notice of Privacy Practices for my ease of reference. I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations). The above entity(ies) may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party.

SPECIAL AUTHORIZATION (if applicable)

If you are authorizing the above entity(ies) to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.

- | | | |
|--------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| _____
Parent/guardian | _____
Patient/athlete | My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted above. |
| _____
Parent/guardian | _____
Patient/athlete | My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation and/or neuro-psychological information may be released to the recipient noted above. |
| _____
Parent/guardian | _____
Patient/athlete | My testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted above. |

AUTHORIZATION SIGNATURES

Date: _____ Patient/Athlete Signature: _____

Date: _____ Witness Signature: _____

Date: _____ Parent/Guardian Signature: _____

Date: _____ Witness Signature: _____

*****COPY OF COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT*****

Copy: Medical Record

Copy: Patient