*RECERTIFICATION FORM

BISHOP McDEVITT
ATHLETIC PHYSICAL
2016-2017 School Year

Parents and Student-Athletes:

1. All athletes must have a physical to participate in the PIAA sanctioned athletic event as required by the PA Department of Health (Physicals by a family Doctor must be dated less than six weeks before the season begins – not on or before June 1st, 2016).
2. Physicals will be given at Bishop McDevitt in our school training room and there will be a $15 charge for the physical. A recertification is free of charge as you are only handing in a form to the athletic office.
3. *Please complete all information in this packet. Parent/Guardian signatures are required in several places. If the packet is not filled out completely, you may not get a physical. No exceptions!
4. All students must have medical insurance. If you do not have adequate coverage please see the athletic director immediately to discuss available options.
5. There is an athletic participation fee at Bishop McDevitt. The fee is $75.00 per athlete for their first sport and $50.00 for a second sport. A third sport is free of charge. Checks should be made payable to: Bishop McDevitt High School, and on the memo line please indicate which sport is being played.
6. Tryouts/First official day of practice begins Monday, March 6th.

******The athlete should have two (2) checks written to "Bishop McDevitt HS" with them. One is the $75 registration fee and the other is the $15 fee for the physician. The monies go in separate areas and that is why we are asking for two (2) checks. Thank you for your cooperation on that matter.**

Physical Schedule: Wednesday, February 22nd

Girls 9:00 - 10:00 AM
Boys 10:00 AM- 11:00 AM

Please direct any questions to your respective coaches or the new athletic trainer Aaron Cusma at 717-236-7973 x2360.

Go Crusaders!

Mr. Tommy Mealy
Athletic Director

Bishop McDevitt Sports Medicine

As we continue our academic year and athletic seasons we are proud to continue our partnership with Select Physical Therapy and Pinnacle Sports Medicine. Select Physical Therapy provides an on-site athletic trainer for sports medicine coverage at Bishop McDevitt High School. Athletic Trainers are allied healthcare professionals responsible for prevention, treatment, and care of athletic injuries. The athletic trainer is also responsible for collecting pre-participation physicals and coordinating return to play plans after an injury. Athletes at Bishop McDevitt should report to the athletic trainer any time they have an injury or concern during sports for an evaluation and a treatment plan for their injury.

Select Physical Therapy also offers team physical therapy services to Bishop McDevitt student athletes. Although some rehab can be done in the athletic training room at the school, some injuries require a more intensive rehab plan. Select Physical Therapy strives to offer the most convenient appointments to parents and students. Select Physical Therapy offers services at all of their locations, while the team physical therapist for Bishop McDevitt athletics works out of the Arlington Avenue location in Harrisburg.

Pinnacle Sports Medicine continues to provide team physician services for Bishop McDevitt athletics. Pinnacle Sports Medicine offers a primary care approach to sports medicine with convenient scheduling and ease of access to all Bishop McDevitt athletes. Pinnacle Sports Medicine treats all injuries from sprains and strains to concussions. Pinnacle offers quick access when xrays are needed and most appointments can be scheduled within 24 hours from the injury.

As always, the sports medicine team at Bishop McDevitt is here to offer help in any way possible. Appointments with either the team physical therapist or team physician can be coordinated through the athletic trainer. If you have any questions you may contact the athletic training room directly at 717-236-7973 ext 2360. More information on the sports medicine team can be found at www.bishopmcdevitt.org/sports-medicine/. Best of luck to all athletes on a successful winter sports season!

Aaron Cusma LAT, ATC

Athletic Trainer, Select Physical Therapy
Bishop McDevitt High School
(717) 236-7973 ext 2360
acusma@bishopmcdevitt.org

Sports Medicine Team contact info:

Doug Fickes
Team Physical Therapist
Select Physical Therapy
Office: (717) 657-8240

Dr Michael Cordas
Team Doctor
Pinnacle Sports Medicine
Office: (717) 791-2620

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 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
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?	☐	☐
2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?	☐	☐
4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	☐	☐
5. Since completion of the CIPPE, 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:

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 8: Re-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 6 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 8 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, 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 none 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 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 6 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_____