



**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 six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 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 authorized earlier than May 1st and shall be effective, regardless of when performed during a school year, until the latter of the next April 30th or the conclusion of the spring sports season.

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 7 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 8 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student's Name _____ Male/Female (circle one)

Student's Date of Birth: ___/___/___ Student's Age on Last Birthday: _____ Grade ___ for 2026- 2027_ School Year

Current Physical Address _____

Current Home Phone # () _____ Parent/Guardian Current Cellular Phone # () _____

Parent/Guardian E-mail Address: _____

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 or Other Medical Personnel Should be Aware _____

Student's Prescription Medications and conditions of which they are being prescribed _____

Section 2: Certification of Parent/Guardian

I hereby give my consent for _____ born on _____ who turned _____ on his/her last birthday, a student of **Ridgway Middle-High** School and a resident of the **Ridgway** public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 2026-2027 school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

Sport	Parent/Guardian Signature	Sport	Parent/Guardian Signature
FALL		WINTER	
Cheerleading 7-12		Basketball 10-12 (Boys)	
Football 7-12		Basketball 9 (Boys)	
Golf 9-12		Basketball 8 (Boys)	
Soccer 9-12		Basketball 7 (Boys)	
Soccer 7-8 (Co-Ed)		Basketball 9-12 (Girls)	
Volleyball 9-12 (Girls)		Gymnastics 9-12	
X-Country (Co-Ed)		Wrestling 9-12	
Basketball 8th (Girls)		Wrestling 7-8	
Basketball 7th (Girls)		Cheerleading 7-12	
Tennis 9-12 (Girls)		Volleyball 7-8 (Girls)	

1. Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member's schools to participate in Inter-School Practices or Scrimmages and 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 ____/____/____

2. 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 ____/____/____

3. 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 on 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 ____/____/____

4. 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 or Scrimmages and Contests. Further, this authorization permit, 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. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein name student.

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

5. Authorization for transportation and treatment: We hereby authorize school personnel to transport herein named student to a physician's office and/or emergency room for treatment in the event that emergency medical care is needed while the student is involved in an athletic sport.

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

6. Understanding of medical insurance coverage: I hereby acknowledge that I understand that the Ridgway Area School District **DOES NOT** provide student medical insurance coverage for any athletic program. Participants in interscholastic athletics must provide proof of medical insurance before being deemed eligible to play. I understand that I must notify the High School Principal or Athletic Director immediately if coverage for the herein named student is dropped during the season.

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

7. Confidentiality: The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school's athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardians(s).

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

SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body.
- Can change the way a student's brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been "dinged" or "had their bell rung."

All concussions are serious. A concussion can affect a student's ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student's brain time to heal.

What are the symptoms of a concussion?

Concussions cannot be seen; however, in a potentially concussed student, **one or more** of the symptoms listed below may become apparent and/or that the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should students do if they believe that they or someone else may have a concussion?

- **Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.
- **The student should be evaluated.** A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.
- **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

How can students prevent a concussion? Every sport is different, but there are steps students can take to protect themselves.

- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:
 - The right equipment for the sport, position, or activity;
 - Worn correctly and the correct size and fit; and
 - Used every time the student Practices and/or competes.
- Follow the Coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If a student believes they may have a concussion: Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student's Signature _____ Date ____/____/____

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

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

SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) occurs when the heart suddenly and unexpectedly stops beating. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

There are about 350,000 cardiac arrests that occur outside of hospitals each year. More than 10,000 individuals under the age of 25 die of SCA each year. SCA is the number one killer of student athletes and the leading cause of death on school campuses.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as

- Dizziness or lightheadedness when exercising;
- Fainting or passing out during or after exercising;
- Shortness of breath or difficulty breathing with exercise, that is not asthma related;
- Racing, skipped beats or fluttering heartbeat (palpitations)
- Fatigue (extreme or recent onset of tiredness)
- Weakness;
- Chest pains/pressure or tightness during or after exercise.

These symptoms can be unclear and confusing in athletes. Some may ignore the signs or think they are normal results off physical exhaustion. If the conditions that cause SCA are diagnosed and treated before a life-threatening event, sudden cardiac death can be prevented in many young athletes.

What are the risks of practicing or playing after experiencing these symptoms?

There are significant risks associated with continuing to practice or play after experiencing these symptoms. The symptoms might mean something is wrong and the athlete should be checked before returning to play. When the heart stops due to cardiac arrest, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience a SCA die from it; survival rates are below 10%.

Act 73 – Peyton's Law - Electrocardiogram testing for student athletes

The Act is intended to help keep student-athletes safe while practicing or playing by providing education about SCA and by requiring notification to parents that you can request, at your expense, an electrocardiogram (EKG or ECG) as part of the physical examination to help uncover hidden heart issues that can lead to SCA.

Why do heart conditions that put youth at risk go undetected?

- Up to 90 percent of underlying heart issues are missed when using only the history and physical exam;
- Most heart conditions that can lead to SCA are not detectable by listening to the heart with a stethoscope during a routine physical; and
- Often, youth don't report or recognize symptoms of a potential heart condition.

What is an electrocardiogram (EKG or ECG)?

An ECG/EKG is a quick, painless and noninvasive test that measures and records a moment in time of the heart's electrical activity. Small electrode patches are attached to the skin of your chest, arms and legs by a technician. An ECG/EKG provides information about the structure, function, rate and rhythm of the heart.

Why add an ECG/EKG to the physical examination?

Adding an ECG/EKG to the history and physical exam can suggest further testing or help identify up to two-thirds of heart conditions that can lead to SCA. An ECG/EKG can be ordered by your physician for screening for cardiovascular disease or for a variety of symptoms such as chest pain, palpitations, dizziness, fainting, or family history of heart disease.

- ECG/EKG screenings should be considered every 1-2 years because young hearts grow and change.
- ECG/EKG screenings may increase sensitivity for detection of undiagnosed cardiac disease but may not prevent SCA.
- ECG/EKG screenings with abnormal findings should be evaluated by trained physicians.
- If the ECG/EKG screening has abnormal findings, additional testing may need to be done (with associated cost and risk) before a diagnosis can be made, and may prevent the student from participating in sports for a short period of time until the testing is completed and more specific recommendations can be made.
- The ECG/EKG can have false positive findings, suggesting an abnormality that does not really exist (false positive findings occur less when ECG/EKGs are read by a medical practitioner proficient in ECG/EKG interpretation of children, adolescents and young athletes).
- ECGs/EKGs result in fewer false positives than simply using the current history and physical exam.

The American College of Cardiology/American Heart Association guidelines do not recommend an ECG or EKG in asymptomatic patients but do support local programs in which ECG or EKG can be applied with high-quality resources.

Removal from play/return to play

Any student-athlete who has signs or symptoms of SCA must be removed from play (which includes all athletic activity). The symptoms can happen before, during, or after activity.

Before returning to play, the athlete must be evaluated and cleared. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed this form and understand the symptoms and warning signs of SCA. I have also read the information about the electrocardiogram testing and how it may help to detect hidden heart issues.

Signature of Student-Athlete

Print Student-Athlete's Name

Date ____/____/____

Signature of Parent/Guardian

Print Parent/Guardian's Name

Date ____/____/____

SECTION 5: HEALTH HISTORY

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

<p>1. Has a doctor ever denied or restricted your participation in sport(s) for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you have an ongoing medical condition (like asthma or diabetes)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Has a doctor ever told you that you have (check all that apply):</p> <p><input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection</p> <p>10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Does anyone in your family have a heart problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Does anyone in your family have Marfan Syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever spent the night in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; padding: 5px;"> <p>17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, circle affected area below:</p> <p>18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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"/> Yes <input type="checkbox"/> No</p> </div> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%;">Head</td> <td style="width: 12.5%;">Neck</td> <td style="width: 12.5%;">Shoulder</td> <td style="width: 12.5%;">Upper arm</td> <td style="width: 12.5%;">Elbow</td> <td style="width: 12.5%;">Forearm</td> <td style="width: 12.5%;">Hand/ Fingers</td> <td style="width: 12.5%;">Chest</td> </tr> <tr> <td>Upper back</td> <td>Lower back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/shin</td> <td>Ankle</td> <td>Foot/ Toes</td> </tr> </table> <p>20. Have you ever had a stress fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Do you regularly use a brace or assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest	Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes	<p>23. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Is there anyone in your family who has asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Have you ever had a herpes skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; padding: 5px;"> <p>CONCUSSION OR TRAUMATIC BRAIN INJURY</p> <p>31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Do you experience dizziness and/or headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </div> <p>34. Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Are you unhappy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>MENSTRUAL QUESTIONS- IF APPLICABLE</p> <p>47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. How old were you when you had your first menstrual period? _____</p> <p>49. How many periods have you had in the last 12 months? _____</p> <p>50. When was your last menstrual period? _____</p>
Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest										
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes										

#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: 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 _____ for 20____ - 20____
School Year

Enrolled in _____ School Sport(s) _____

Height _____ Weight _____ % Body Fat (optional) _____ Brachial Artery BP _____ / _____ (_____ / _____ , _____ / _____) RP _____

If either the brachial artery 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		<input type="checkbox"/> Heart murmur <input type="checkbox"/> Femoral pulses to exclude aortic coarctation <input type="checkbox"/> Physical stigmata of Marfan syndrome
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) Certification Date of CIPPE ____/____/____

RASD RIDGWAY AREA SCHOOL DISTRICT **RASD**
 1403 Hill Street
 RIDGWAY, PA 15853

IMPORTANT: Send information to the above mailing address

MIDDLE/ HIGH SCHOOL OFFICE
 TEL: 814/773-3164
 FAX: 814/773-4247

WRITTEN AUTHORIZATION TO REQUEST / RELEASE STUDENT RECORDS

TO: Penn Highland Occupational Health DATE OF REQUEST: _____
Ridgway Campus

RE: _____ STUDENT DOB: _____

Request / Release to an Agency

The following information is requested / released in order to: Comply with RASD Random Drug Testing Policy #227.1

- | | |
|---|--|
| <input type="checkbox"/> Psychiatric Reports (May include PHI*) | <input type="checkbox"/> Progress Notes (May include PHI*) |
| <input type="checkbox"/> Psychological Reports (May include PHI*) Medical | <input type="checkbox"/> Academic Records |
| <input type="checkbox"/> Treatment / History (May include PHI*) Social | <input type="checkbox"/> Special Education Records (May include PHI*) |
| <input type="checkbox"/> Casework Reports (May include PHI*) | <input type="checkbox"/> Probation (May include PHI*) |
| <input type="checkbox"/> Counseling / Therapy Records (May include PHI*) | <input type="checkbox"/> Discharge Summary (May include PHI*) |
| <input type="checkbox"/> Intake Data & Social History (May include PHI*) | <input type="checkbox"/> Recommendations (May include PHI*) |
| <input type="checkbox"/> Individual Service/Treatment Plan | <input type="checkbox"/> Exchange of Verbal Information (May include PHI*) |
| <input checked="" type="checkbox"/> <u>Other: Drug Testing</u> | |

***PHI – Protected Health Information**
 I/We understand the following:

- The designated information will be exchanged with the understanding that absolute confidentiality will be maintained.
- Photocopies of this authorization shall be considered valid.
- This written authorization shall expire one year from the date signed.
- This written authorization may be revoked at any time by notifying, in writing, the Privacy Officer in the Office of Student Services at the above address.
- The identified agency and its staff/employees have no responsibility or liability as a result of any re-disclosure.
- I/We am entitled to a copy of this Written Authorization form.

 SIGNATURE OF PARENT/GUARDIAN

 DATE OF SIGNATURE

 SIGNATURE OF STUDENT

 DATE OF SIGNATURE

Thank you for your assistance and timely attention to this request. Please send records to the attention of Mr. Richard Viglione, Athletic Director at the office specified above.

RANDOM DRUG TESTING OF STUDENTS WHO PARTICIPATE IN COMPETITIVE EXTRACURRICULAR ACTIVITIES

227.1. Attachment 1 May, 2026

Includes: All students, who participate in competitive extracurricular activities at the Ridgway Area Middle/High School, consent to a random urine screen during the period that the activity in which s/he participates throughout the school year is in session. Policy #227.1 defines competitive extracurricular activities to include, but not be limited to the following: athletic competitions and programs; cheerleading; band; choir; The First Robotics Team; Computer Fair Participants; Scholastic Scrimmage Team; Stand Tall etc.

Purpose: The Ridgway Area School District has the responsibility to enact broad discretionary authority to maintain safety, order and discipline in school and during school sponsored activities. The administration recognizes that substance abuse among the student population is becoming increasingly more predominant. Administrators, teachers and coaches recognize that drugs have a deleterious effect on the motivation, memory, judgment, reaction time, coordination, and performance of students participating in competitive extra-curricular activities. Administrators, teachers and coaches also recognize that students participating in competitive extra-curricular activities increase their exposure to intense physical demands on their bodies and intense mental strain on their minds. Students participating in extra-curricular activities must endure the responsibility of taking an active role in ensuring their personal health, safety, and welfare, as well as the health, safety, and welfare of their teammates with whom they engage in extra-curricular activities. Student participation in middle and high school athletic programs requires that students increase their level of physical exertion and requires that students are physically interdependent on teammates. Being under the influence of a body or mind-altering substance has the potential to impact an individual athlete's health. Substance use/abuse by student athletes also decreases the expectation of safety that all students who are participating in athletics are entitled to. It is important to understand that random urine screens are not being used for disciplinary purpose. They are being used to ensure that all students participating in competitive extra-curricular activities have the opportunity to do so in an environment that is safe and conducive to exhibitions that maximize athletic skills and intellectual capabilities.

Selection: The selection of students, who shall be required to submit to a urine screen, is done so in a random and confidential manner by the middle/high school administration. Administration shall use the computerized random selection program. Two percent of the total number of students participating in an activity will be selected one time per week. When a student is selected, the parent will be notified on the date the test will take place. Student and parent must sign a testing consent form or be dropped from the activity. Students will be transported either by parent or administration to Elk Regional Health Center Occupational Health at the specified time scheduled by the administration. Students who fail to report to Elk Regional Health Center Occupational Health for a random urine screen will be dropped from the activity. Testing results are held in the strictest of confidence. The urine screening will continue to be supervised by Occupational Health personnel. All legal rulings for chain of custody will be observed at both the collections sites and the analysis site. (*Chain of custody refers to the security of handling the obtained urine sample from the point of collection to the final destination of the laboratory. This includes identification, labeling, sealing, and testing.*) Occupational Health will notify the school administration of the test results.

Results: If the test is negative, no further action is taken. The administration will receive a CONFIDENTIAL report of the positive test results, when confirmed by Occupational Health. The administration will promptly notify the parents of the student athlete.

Students who test positive will be notified by the building principal and will be:

1. required to meet with the building principal and his/her parent(s)/guardian(s).
2. offered the opportunity to meet with their family physician at the parent(s)/guardian(s) cost
3. required to participate in the RHS student assistance program - REACH and complete a drug and alcohol assessment.
4. required to comply with the drug and alcohol counselor's recommendations based upon the assessment.
5. dismissed from the athletic program or extra-curricular activity if he/she fail to comply with the counselor's recommendations.
6. informed of the disciplinary action that will follow should the student be noncompliant with the policy:
 - 1st offense - parent recommendation
 - 2nd offense - suspension from the athletic event
 - 3rd offense - banned from any future athletic competition, unless reinstated by the Ridgway Area School Board.
7. required to be retested after 8 weeks or before the start of another sports season, in which he/she will be a team participant and test negative prior to his/her return to athletic competition.

If anyone has anyone questions regarding this policy, please contact Noel Petrosky, superintendent at 814-773-3146.

Random Drug Testing -- Consent to Test

I hereby give permission for the Ridgway Area School District and Penn Highlands Health Center Occupational Health to perform a urine drug screen on my son/daughter, through the random selection process as outlined in School Board Policy #227.1. I understand that my son/daughter is eligible for selection during the time period in which he/she participates in competitive extracurricular activities. I understand that I may request to be present when my son/daughter is being tested. The cost of the random urine screen, lab analysis and drug and alcohol /assessment/counseling will be covered by the Ridgway Area School District. All test results will be confidential.

I understand that the Ridgway Area School District has the responsibility to enact broad discretionary authority to maintain safety, order and discipline in school and during school sponsored activities. I understand that student participation in middle and high school athletic programs and extra-curricular activities requires that students increase their level of physical and mental exertion and requires that students are physically interdependent on other students and staff. Being under the influence of a body or mind-altering substance has the potential to impact an individual's health and performance. Substance use/abuse by students also decreases the expectation of safety that all students who are participating in athletics and extra-curricular activities are entitled to.

I realize the ramifications of positive test results. I agree to follow the guidelines set forth for positive test results. I understand that my son/daughter will not be disciplined by school suspension or expulsion for a positive test result. I understand that I may request that they be disqualified from the sport or extra-curricular activity for a first offense. I understand that action and sanctions for 2nd and 3rd offenses are governed by the school administration as outlined in policy (#227.1). I understand that my son/daughter will be required to comply with specific guidelines for further athletic and extra-curricular consideration as set forth in this policy.

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

As a student participating in an extra-curricular activity, I agree to participate in the random urine screening process to be conducted during the period of time for which I am enrolled and eligible to participate in the activity. I have read and understand the information provided in this permission to test form.

Student's Name Printed: _____ Student's Signature _____ Date / /

RIDGWAY AREA SCHOOL DISTRICT
TRANSPORTATION WAIVER AND RELEASE
SPRING ATHLETIC CO-OP SPORTS

HOSTED BY JOHNSONBURG AREA SCHOOL DSITRICT

The Ridgway Area School District ("District") provides transportation to all District student athletes who participate in spring sports through the board approved cooperative PIAA athletic agreement with the Johnsonburg Area School District (JASD). These include: jv/v baseball, jh/jv/v softball and jh/v track practices and home contests. The District strongly encourages students to utilize District-provided transportation to and from the practices as scheduled at the dates/times locations from the Johnsonburg Area School District.

You, the parent/legal guardian of _____ ("Student"), and your Student are hereby waiving Student's right to utilize District-provided transportation to and from JASD for spring cooperative sport practices/home contests and are knowingly and voluntarily signing this release. If you or your Student decide s/he wants to utilize District-provided transportation to/from JASD for spring cooperative sport practices/home contests, please inform the RASD athletic director in writing and transportation will be provided.

RELEASE: I/we, the parents/legal guardians of Student, hereby give Student approval to decline to utilize District-provided transportation to/from JASD for spring cooperative sports practices/home contests and authorize Student to drive him/herself to/from the scheduled practice/home contest site. I/we, the parents/legal guardians of Student understand that the student is NOT permitted to drive any other RASD student athletes participating in the board approved cooperative PIAA athletic agreement with the Johnsonburg Area School District (JASD) to/from scheduled practices/home contest site. Student's failure to comply with this stipulation will result in disciplinary consequences of the RMHS Administration.

By signing this Transportation Waiver and Release, I/we voluntarily agree to the following waiver and release of liability: I/we agree to release and discharge all claims for ourselves, our heirs, and as a parent or legal guardian for the Student, against the Ridgway Area School District, its Board of Directors, successors, assigns, officers, agents, employees, and volunteers and will hold them harmless from any and all liability or demands for personal injury, psychological injury, sickness, death, or claims resulting from personal injury, death or property damage, of any nature whatsoever which may be incurred by the Student or the undersigned relating to or as a result of the Student's decision to provide his/her own transportation to/from JASD and all related JASD spring cooperative sports practices/home events.

(STUDENT)

(PARENT/GUARDIAN)

Date: _____

(PARENT/GUARDIAN)

