CEDAR CLIFF HIGH SCHOOL

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2019-2020

Dear Parent or Guardian:

Your child has expressed an interest in participating in an athletic program at Cedar Cliff High School. These are programs for those students desiring a level of competition beyond that provided in the physical education program. An activity fee is required for participation in athletics and student activities. The fee will be assessed per sport and activity. There is a student cap of $200.00 and a family cap of $500.00. Checks or money orders are to be made payable to Cedar Cliff High School. Checks, money orders or cash are submitted to the main office only. Fees and the activity fee payment form **must be paid** and submitted within two (2) weeks of the start of practice and no later than the first (1st) competition date.

The winter sports season begins Monday, November 18, 2019. Individual coaches will let their players know at what time and place to pick up any required equipment. The individual coaches will let the athletes know where practice is and when it starts.

ALL RE-CERTIFICATION PAPERWORK IS DUE TO CEDAR CLIFF HIGH SCHOOL ONE (1) WEEK BEFORE THE OFFICIAL PIAA PRACTICE FOR THE SEASON BEGINS. ANY PAPERWORK TURNED IN AFTER THIS DATE WILL RESULT IN STUDENT MISSING AT MINIMUM THE FIRST DAY OF PRACTICE/TRYOUTS.

Winter Sports Offered at Cedar Cliff High School

Boys Basketball	Head Coach	Tigh Savercool	(Grades 9-12)	tsave31@gmail.com
Girls Basketball	Head Coach	Scott Weyant	(Grades 9-12)	sweyant@wssd.k12.pa.us
Wrestling	Head Coach	Robert Rapsey	(Grades 9-12)	Robert17055@verizon.net
Boys and Girls Swimming/	Head Coach	Joseph Chubb	(Grades 9-12)	coachchubb@gmail.com
WSSD Diving	Head Coach		(Grades 9-12)	

Junior High/Freshman Winter Sports:

Boys Basketball (9th)	Head Coach	Nathan Miller		natem1132@comcast.net
Girls Basketball (9th)	Head Coach	Anita Uibel		auibel@verizon.net
Boys Basketball (Junior High)	Head Coach	Chris Houser	(Grades 7-8)	chouser259@hotmail.com
Girls Basketball (Junior High)	Head Coach	Frank Karli	(Grades 7-8)	fkarli@thsrocks.com
Wrestling (9th)	Head Coach	Robert Lewis	(Grades 7-9)	lewisrw76@gmail.com

Athletic Trainer:

Athletic Trainer	Head Trainer	Kristin Lyons	klyons@wssd.k12.pa.us
Athletic Trainer	Asst. Trainer (Trainer B)		

****All physicals must be turned into the athletic trainer no later than Monday, November 11, 2019.**

RE-CERT PHYSICAL PACKET

WEST SHORE SCHOOL DISTRICT
HIGH SCHOOL AND MIDDLE SCHOOL
Re-Certification Checklist

Submit checklist with completed packet materials. Please print information.

Student Name: _____

School: _____

Sport: _____

Follow checklist per criteria listed below.

Re-Certification Packet

(For those who have already competed in a school sport during the current school year or previously turned in a completed Physical Packet (Full).

☐ Complete PIAA Re-Certification Packet

- ☐ Section 7 – Re-Certification by Parent/Guardian (Supplemental Health History Questions)
  - **If** answer **YES** to a/any Supplemental Health History Question(s) on Section 7, then Section 8 is also required.
- ☐ Section 8 – Re-Certification by **Licensed Physician of Medicine or Osteopathic Medicine**

☐ Medical Release/Insurance Form

☐ **Submit Completed Packet to High School Athletic Trainer**

☐ Submit Activity Fee Payment Form or Request for Waiver of Activity Fee Form **to High School Athletic Director** (due by first competition date for your activity).

☐ **FOR HOMESCHOOL, CYBER SCHOOL AND CHARTER SCHOOL STUDENTS ONLY**
Submit Intent to Participate Form
Available on the District website www.wssd.k12.pa.us on the Cedar Cliff and Red Land High School Athletics Department Webpages

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_____

W E S T S H O R E S C H O O L D I S T R I C T

Medical Release/Insurance Form

Please Print: *To be completed and signed by student's parent or guardian.*

School _____ School Year _____ Current Grade _____

Student's Name _____ Date of Birth _____

Student Address _____

Parent/Guardian's Name(s) _____

Address (if different from student) _____

Parent/Guardian's Phone #s
Please list in order of preference for calls.
1. (_____) _____ 3. (_____) _____
2. (_____) _____ 4. (_____) _____

Person to contact in an emergency if unable to reach parent/guardian:

Contact Name _____ Phone # (_____) _____

Family Physician _____ Phone # (_____) _____

Medical Insurance

Name of Company _____ Policy # _____

Name of Employing Company _____

Company Address _____

Medical Record

Complete all lines even if only with the words "None" or "Not Applicable"

Allergies to Medication _____

Other Allergies _____

Serious Illnesses _____

Current Medication(s) _____

Other Health Problems _____

Date of Last Tetanus Shot _____

Parental Consent

I hereby give consent for my child, _____ to participate in _____ and declare that we have either school insurance or family insurance to cover any accidents, and in consideration of my child's participation in said school activity. I hereby release the West Shore School District, its directors, agents, and employees of all responsibility and liability, for loss or injury to his/her person or property.

Parent/Guardian's Signature _____ Date _____

I consent for a qualified physician to perform any medical or surgical procedures he deems advisable to the welfare of this applicant while he/she is participating in school-supervised events. Further, this authorization permits said physician to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for this applicant. The undersigned does hereby assume and agree to pay any indebtedness or physician's and surgeon's fees and hospital charges for such services.

Parent/Guardian's Signature _____ Date _____

Relationship to Student _____