



**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 seven Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, 5 and 6 by the student and parent/guardian; and Section 7 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 June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st 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 8 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 9 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 # () _____

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

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

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	
Girls' Lacrosse	
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
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 video broadcasts and re-broadcasts, webcasts and 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. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 7 regarding a medical condition or injury to the herein named student.

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

F. 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 guardian(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 of 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: SUPPLEMENTAL ACKNOWLEDGEMENT, WAIVER AND RELEASE: COVID-19

The COVID-19 pandemic presents athletes with a myriad of challenges concerning this highly contagious illness. Some severe outcomes have been reported in children, and even a child with a mild or even asymptomatic case of COVID-19 can spread the infection to others who may be far more vulnerable.

While it is not possible to eliminate all risk of being infected with or furthering the spread of COVID-19, PIAA has urged all member schools to take necessary precautions and comply with guidelines from the federal, state, and local governments, the CDC and the PA Departments of Health and Education to reduce the risks to athletes, coaches, and their families. As knowledge regarding COVID-19 is constantly changing, PIAA reserves the right to adjust and implement precautionary methods as necessary to decrease the risk of exposure to athletes, coaches and other involved persons. Additionally, each school has been required to adopt internal protocols to reduce the risk of transmission.

The undersigned acknowledge that they are aware of the highly contagious nature of COVID-19 and the risks that they may be exposed to or contract COVID-19 or other communicable diseases by permitting the undersigned student to participate in interscholastic athletics. We understand and acknowledge that such exposure or infection may result in serious illness, personal injury, permanent disability or death. We acknowledge that this risk may result from or be compounded by the actions, omissions, or negligence of others. The undersigned further acknowledge that certain vulnerable individuals may have greater health risks associated with exposure to COVID-19, including individuals with serious underlying health conditions such as, but not limited to: high blood pressure, chronic lung disease, diabetes, asthma, and those whose immune systems that are compromised by chemotherapy for cancer, and other conditions requiring such therapy. While particular recommendations and personal discipline may reduce the risks associated with participating in athletics during the COVID-19 pandemic, these risks do exist. Additionally, persons with COVID-19 may transmit the disease to others who may be at higher risk of severe complications.

By signing this form, the undersigned acknowledge, after having undertaken to review and understand both symptoms and possible consequences of infection, that we understand that participation in interscholastic athletics during the COVID-19 pandemic is strictly voluntary and that we agree that the undersigned student may participate in such interscholastic athletics. The undersigned also understand that student participants will, in the course of competition, interact with and likely have contact with athletes from their own, as well as other, schools, including schools from other areas of the Commonwealth. Moreover, they understand and acknowledge that our school, PIAA and its member schools cannot guarantee that transmission will not occur for those participating in interscholastic athletics.

NOTWITHSTANDING THE RISKS ASSOCIATED WITH COVID-19, WE ACKNOWLEDGE THAT WE ARE VOLUNTARILY ALLOWING STUDENT TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS WITH KNOWLEDGE OF THE DANGER INVOLVED. WE HEREBY AGREE TO ACCEPT AND ASSUME ALL RISKS OF PERSONAL INJURY, ILLNESS, DISABILITY AND/OR DEATH RELATED TO COVID-19, ARISING FROM SUCH PARTICIPATION, WHETHER CAUSED BY THE NEGLIGENCE OF PIAA OR OTHERWISE.

We hereby expressly waive and release any and all claims, now known or hereafter known, against the student's school, PIAA, and its officers, directors, employees, agents, members, successors, and assigns (collectively, "**Releasees**"), on account of injury, illness, disability, death, or property damage arising out of or attributable to Student's participation in interscholastic athletics and being exposed to or contracting COVID-19, whether arising out of the negligence of PIAA or any Releasees or otherwise. We covenant not to make or bring any such claim against PIAA or any other Releasee, and forever release and discharge PIAA and all other Releasees from liability under such claims.

Additionally, we shall defend, indemnify, and hold harmless the student's school, PIAA and all other Releasees against any and all losses, damages, liabilities, deficiencies, claims, actions, judgments, settlements, interest, awards, penalties, fines, costs, or expenses of whatever kind, including attorney fees, fees, and the costs of enforcing any right to indemnification and the cost of pursuing any insurance providers, incurred by/awarded against the student's school, PIAA or any other Releasees in a final judgment arising out of or resulting from any claim by, or on behalf of, any of us related to COVID-19.

We willingly agree to comply with the stated guidelines put forth by the student's school and PIAA to limit the exposure and spread of COVID-19 and other communicable diseases. We certify that the student is, to the best of our knowledge, in good physical condition and allow participation in this sport at our own risk. By signing this Supplement, we acknowledge that we have received and reviewed the student's school athletic plan.

Date: _____

Signature of Student

Print Student's Name

Signature of Parent/Guardian
Revised – October 7, 2020

Print Parent/Guardian's Name

SECTION 6: 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 ever 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 TRAUMATIC BRAIN INJURY 31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? <input type="checkbox"/> <input type="checkbox"/> 32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> <input type="checkbox"/> 33. Do you experience dizziness and/or headaches with exercise? <input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			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"/>
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	<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"/>
11. Has anyone in your family died for no apparent reason?	<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"/>
12. Does anyone in your family have a heart problem?	<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"/>
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"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?			42. Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
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? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	44. Has anyone recommended you change your weight or eating habits?	<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:	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
Head Neck Shoulder Upper arm Elbow Forearm Hand/Fingers Chest			46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/Toes			FEMALES ONLY	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	48. How old were you when you had your first menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	49. How many periods have you had in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
			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 7: 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) _____ 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
Cardiopulmonary		<input type="checkbox"/> Physical stigmata of Marfan syndrome
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 ____/____/____

SECTION 8: 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 9, 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 _____

Parent/Guardian E-mail Address: _____

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 # () _____

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 9, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

**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 a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? | <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"/> |
| 2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? | <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"/> |
| | | | 5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills? | <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"/> |

An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below

#s	Explain yes answers; include injury, type of treatment & the name of the medical professional seen by student

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 9: 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 9 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 6 and 7 of the herein named student's previously completed CIPPE Form. Section 8 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 8.

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 7 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 7 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 10: 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.



DEPARTMENT OF ATHLETICS

Athletic Director: Thomas Kayda

2005 EAGLE RIDGE ROAD SOUTH PARK, PA 15129-8885

(412) 655-3111 (VOICE) (412) 655-4505 (FAX)

ACKNOWLEDGEMENT OF ATHLETIC MANUAL

Please visit www.sparksd.org on the athletic homepage, under "Links" to access the Athletic Manual

I _____ have read the South Park High
(Name of Athlete)
School Athletic Manual. I pledge that I will **NOT** participate (even willingly), in
ANY hazing activities. I fully understand the responsibilities of becoming a
participating South Park School District Athletic Team Member.

Athlete's Signature: _____ Date: _____

And

We/I as the parent/guardian of _____
(Name of Athlete)
have read the Athletic Manual for student athletes and fully understand the
responsibilities of our son/daughter and ourselves, while he/she is participating as a
South Park School District Athletic Team Member.

Parent/Guardian Signature: _____ Date: _____



INFORMATIVE WEBSITES

WWW.SPARKSD.ORG – On the athletic webpage: Directions, Schedules, NCAA information (on page 7 of Guidance Handbook) and other information on athletic programs.

WWW.SOUTHPARKWPAL.ORG- See rSchoolToday for schedules, postponements and cancellations. Parents can sign up to be notified of the most current schedule changes. This is extremely helpful during the spring sports season, when postponements and cancellations occur almost daily. South Park School District reserves the right to postpone or move an athletic event when circumstances dictate the need, including but not limited to the last minute of an event. Web –based scheduling provides the most up to date version of particular athletic events. *Please remember that it is more than likely that these changes will not be reflected on printed hard copies of previous schedules.*

WWW.THECOACHES CIRCLE- Very important for the potential college athlete. Provides information that you may need to help an athlete play at the next level.

Parental Release and Indemnification Agreement

The undersigned hereby request(s) South Park School District to permit the following STUDENT to participate in the following "ACTIVITY" _____

STUDENT _____ AGE _____ PHONE _____ EMERGENCY _____

SCHOOL: _____ GRADE _____

The undersigned agree(s) to the following:

FIRST: CERTIFICATE OF GOOD HEALTH - The undersigned do/does accept the responsibility for STUDENT's physical examination. It is hereby CERTIFIED the STUDENT has no known physical condition which could be affected by participating in the above activity and the STUDENT is in good health at the present.

SECOND: RELEASE IN FULL - The undersigned releases the South Park School District and all of the members of its Board of Directors, its administration, teachers, instructors and coaches from all claims, and all consequential damages on account of, or in any way arising out of, ALL PERSONAL INJURIES AND/OR DEATH which may result from STUDENT's participating in the activity program aforesaid.

THIRD: ASSUMPTION OF RISK - The undersigned have/has acknowledged and are/is aware that the above activity may require intense bodily contact and/or many traumatic events, any of which are capable of causing injury and possible death. We/I do, therefore, ASSUME ALL RISK OF INJURY OR DEATH and acknowledge that we/I have explained said risks to STUDENT and that STUDENT is willing to participate in said activity program regardless of the aforesaid risks.

FOURTH: INDEMNIFICATION - That in the event of any claim, or suit arises on behalf of or by STUDENT, as a result of his/her participation in the aforesaid activity program, either before or after his/her attaining the age of 18, we the undersigned agree to indemnify, hold harmless and forever defend the South Park School District and all of the members of its Board of Directors, its administration, teachers, instructors and coaches against all claims or payments, etc., arising from our/my STUDENT's participation in the aforesaid activity program as a result of personal injuries, death or other type of harm suffered by him/her or us/me.

FIFTH: LACK OF INSURANCE - The undersigned have/has acknowledged and are aware that the South Park School District and all of the members of its Board of Directors, its administration, teachers, instructors and coaches will not and do not provide any health insurance and/or accident insurance for the STUDENT in relation to his/her participation in the aforesaid activity or activity program.

Intending to be legally bound hereby, having read the above AGREEMENT; we/I do hereby fix our/my hand(s) and seal(s).

Student Athlete Signature

Date

Parent/Guardian Signature

Date

South Park High School Athletics

“The Parents’ Pledge”

Cooperation among coaches, athletes, parents, guardians, and school personnel is essential if students are to realize the value of athletic participation. Like coaches and athletes, parents must make commitments to the athletic program to assure these values. We ask that you read, sign and return the following “PLEDGE” and as needed, discuss your reactions with your child’s coaches or the school Athletic Director as outlined below.

Thank You.

As the parent of an athlete of this school, I promise.....

- To work closely with a school personnel to assume an appropriate academic, as well as athletic experience for my child while he/she is in school.
- To assume that my child will attend all scheduled practices and athletic contests.
- To require my child abide by the athletic department’s training rules.
- To acknowledge that the coach has the ultimate authority to determine a strategy and layer selection and that playing time is **NOT GUARENTEED**. Coaches have the responsibility to put the most competitive team in the contest.
- To promote mature behavior from students and parents during athletic contests.
- To work closely with coaches and other school personnel to identify a reasonable and realistic future for my child as a student athlete.

If you have a concern with a coach, you should.....

- Call the coach to set up an appointment. If the coach cannot be reached, call South Park High School’s Athletic Director, Thomas Kayda at 412-655-3111 and he will be happy to arrange a meeting for you. *Please contact the athletic if have any unresolved concerns.*
- *Most importantly and in the spirit of good sportsmanship*, please do not attempt to confront a coach or engage in discussion with a coach immediately before or after a contest, practice or on game day. These can be highly emotional times for both the coach and parent. Discussions under times of high emotions do not promote the best outcome in the resolution of issues.

Appropriate Concerns for Parents to Discuss with Coaches:	Issues NOT appropriate to discuss with coaches:
1. Treatment of their child	1. Playing time/ positions/ assignments
2. Ways for their child to improve	2. Team strategy
3. Concerns about their child’s behavior	3. Play calling
4. Concern for their child’s health and safety	4. Other students and teammates

Athlete’s Name:_____ Date:_____

Parent/Guardian Signature:_____

Dear Parents and Guardians,

As part of a contractual agreement between UPMC Sports Medicine and the South Park School District, UPMC provides certified athletic trainers to aide in the prevention, recognition, evaluation, and treatment of athletic injuries.

To treat your son or daughter, a form must be signed by parents/guardians of the student-athlete. It will be found on page 9 and 10 of this packet. This form gives the athletic trainers and other associated healthcare personnel permission to assist or participate in providing care in the event of an injury or illness. This form also allows the athletic trainers to communicate with medical personnel and the school district's athletic department personnel, including coaches, in order to provide consultation, treatment, and establish a plan of care for the injured or ill patient.

Please note that this form has no relationship to your health insurance plan and in no way should influence your choice of medical care. UPMC, as the employers of certified athletic trainers in the South Park School District, must have this form completed in order to provide to your son or daughter to comply with privacy and standard consent to treat laws.

In addition, copies of the UPMC Notice of Privacy Practices documents can be viewed at <https://www.upmc.com/patients-visitors/privacy-info/notice-of-privacy-practice>

Please sign the attached document. If you revoke this authorization or consent form, please contact the athletic office at 412-655-3111. We look forward to your student-athlete's safe participation in South Park athletics. Thank you for your time.

Sincerely,

UPMC Sports Medicine

UPMC Sports Medicine is the official medical provider of:



Print Athlete's Name

Sport 1: _____ Sport 2: _____ Sport 3: _____
Print Athlete's Sport(s)

As part of a contractual agreement with UPMC Sports Medicine, certified athletic trainers may aide in the prevention, recognition, evaluation, and treatment of athletic injuries. **Please note that the forms below have**

no relationship to your health insurance plan and in no way, influence your choice of medical care.

UPMC must have these forms completed to comply with privacy and standard consent to treat laws.

(1) UPMC Authorization for Release of Protected Health Information

- I authorize UPMC to provide information related to the athlete's care to family/school/team physicians, school nurses, coaches, athletic directors, school principals, EMS personnel, and such other persons as is necessary needed for them to provide consultation, treatment, establish a plan of care or determine whether the athlete may resume participation in school or sports activities.
- I authorize UPMC to use the athlete's medical information for UPMC internal departmental reporting purposes.
- I authorize UPMC (including its hospitals, other entities and programs) to use medical or other information maintained on electronic information systems or stored in various forms about the athlete's care, health care operations, or payment for treatment and services.
- I understand that the health record(s) released by UPMC may be re-disclosed by the facility/person that receives the record(s) and therefore (1) UPMC and its staff/employees has no responsibility or liability because of the re-disclosure and (2) such information may no longer be protected by federal or state privacy laws.
- I understand that this Authorization is in effect for a period of one year from the date signed by the athlete.
- I understand that this Authorization is in effect if the athlete is treated for an injury during off-season workouts; however, no time frame specified shall go beyond one year from the date of signature.
- I understand that I have the right to revoke this Authorization form at any time by sending a written request to UPMC at the location where the Authorization was provided.
- I understand that my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization. • I understand that I am entitled to a copy of this completed Authorization form.

Print Athlete's NameSport 1: _____ Sport 2: _____ Sport 3: _____
Print Athlete's Sport(s)**(2) UPMC Consent for Treatment and Healthcare Operations**

I consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic injuries. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team physician, school nurse, and licensed physical therapists. Under the direction of a certified athletic trainer, college/university athletic training students and high school student aides may also provide care.

I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

In the event of ImPACT baseline testing, I understand the ImPACT baseline testing provided by UPMC Sports Medicine is not intended to prevent, diagnose, or treat a concussion and is not to be administered following a possible concussion. If the athlete suffers a concussion, the administration of an ImPACT post-test is generally conducted at the discretion of the concussion specialist at their facility.

(3) UPMC Privacy Practices

I understand that copies of the UPMC Notice of Privacy Practices document are available at the school, can be sent in the mail upon my request or viewed at <http://www.upmc.com/patients-visitors/privacy-info/Pages/default.aspx>. I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy Practices.

By signing below, I am acknowledging the above (1) Authorization for Release of Protected Health Information, (2) Consent for Treatment and Healthcare Operations, and (3) Notice of Privacy Practices.

Athlete signature_____
Date_____
Parent or guardian signature/relationship_____
Date_____
Parent or guardian signature/relationship_____
Date

For Office Use Only:

Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices: _____

Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices: _____

ONE OPPORTUNITY. LIMITLESS POSSIBILITIES.

If you want to play sports at an NCAA Division I or II school, start by registering for a Certification Account with the NCAA Eligibility Center at eligibilitycenter.org. If you want to play Division III sports or you aren't sure where you want to compete, start by creating a Profile Page at eligibilitycenter.org.

ACADEMIC REQUIREMENTS

To play sports at a Division I or II school, you must graduate from high school, complete 16 NCAA-approved core courses, earn a minimum GPA and earn an ACT or SAT score that matches your core-course GPA.

CORE COURSES

Only courses that appear on your high school's list of NCAA core courses will count toward the 16 core-course requirement; visit eligibilitycenter.org/courselist for a full list of your high school's approved core courses. Complete 16 core courses in the following areas:

DIVISION I

Complete 10 NCAA core courses, including seven in English, math or natural/physical science, before your seventh semester.

ENGLISH	MATH (Algebra I or higher)	NATURAL/ PHYSICAL SCIENCE (Including one year of lab, if offered)	ADDITIONAL (English, math or natural/physical science)	SOCIAL SCIENCE	ADDITIONAL COURSES (Any area listed to the left, foreign language or comparative religion/philosophy)
4 years	3 years	2 years	1 year	2 years	4 years

DIVISION II

ENGLISH	MATH (Algebra I or higher)	NATURAL/ PHYSICAL SCIENCE (Including one year of lab, if offered)	ADDITIONAL (English, math or natural/physical science)	SOCIAL SCIENCE	ADDITIONAL COURSES (Any area listed to the left, foreign language or comparative religion/philosophy)
3 years	2 years	2 years	3 years	2 years	4 years

GRADE-POINT AVERAGE

The NCAA Eligibility Center calculates your grade-point average based only on the grades you earn in NCAA-approved core courses.

- DI requires a minimum 2.3 GPA.
- DII requires a minimum 2.2 GPA.

SLIDING SCALE

Divisions I and II use sliding scales to match test scores and GPAs to determine eligibility. The sliding scale balances your test score with your GPA. If you have a low test score, you need a higher GPA to be eligible. Find more information about test scores at ncaa.org/test-scores.

TEST SCORES

You may take the SAT or ACT an unlimited number of times before you enroll full time in college. Every time you register for the SAT or ACT, use the NCAA Eligibility Center code 9999 to send your scores directly to us from the testing agency. We accept official scores only from the ACT or SAT, and won't use scores shown on your high school transcript. If you take either test more than once, the best subscore from different tests are used to give you the best possible score.



HIGH SCHOOL TIMELINE

9TH GRADE



- *Start planning now!* Take the right courses and earn the best grades possible.

- Find your high school's list of NCAA-approved core courses at eligibilitycenter.org/courselist.
- Sign up for a free Profile Page at eligibilitycenter.org for information on NCAA requirements.

10TH GRADE

REGISTER



- If you fall behind academically, ask your counselor for help finding approved courses you can take.

- Register for a Profile Page or Certification Account with the NCAA Eligibility Center at eligibilitycenter.org.
- Monitor your Eligibility Center account for next steps.
- At the end of the year, ask your counselor at each high school or program you attended to upload your official transcript to your NCAA Eligibility Center account.

11TH GRADE



- Check with your counselor to make sure you are on track to complete the required number of NCAA-approved courses and graduate on time with your class.

- Take the ACT or SAT and submit your scores to the NCAA Eligibility Center using code 9999.
- Ensure your sports participation information is correct in your Eligibility Center account.
- At the end of the year, ask your counselor at each high school or program you attended to upload your official transcript to your NCAA Eligibility Center account.

12TH GRADE



- Complete your final NCAA-approved core courses as you prepare for graduation.

- Take the ACT or SAT again, if necessary, and submit your scores to the NCAA Eligibility Center using code 9999.
- Request your final amateurism certification beginning April 1 (fall enrollees) or Oct. 1 (winter/spring enrollees) in your NCAA Eligibility Center account at eligibilitycenter.org.
- After you graduate, ask your counselor to upload your final official transcript with proof of graduation to your NCAA Eligibility Center account.
- *Reminder:* Only students on an NCAA Division I or II school's institutional request list will receive a certification.

How to plan your high school courses to meet the 16 core-course requirement:

$$4 \times 4 = 16$$

9TH GRADE

- (1) English
- (1) Math
- (1) Science
- (1) Social Science and/or additional

4 CORE COURSES

10TH GRADE

- (1) English
- (1) Math
- (1) Science
- (1) Social Science and/or additional

4 CORE COURSES

11TH GRADE

- (1) English
- (1) Math
- (1) Science
- (1) Social Science and/or additional

4 CORE COURSES

12TH GRADE

- (1) English
- (1) Math
- (1) Science
- (1) Social Science and/or additional

4 CORE COURSES

For more information: ncaa.org/playcollegesports | eligibilitycenter.org

Search Frequently Asked Questions: ncaa.org/studentfaq

Follow us: @NCAAEC

@playcollegesports

@ncaaec