

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 the student's first sport in a school year, the student is required to complete a physical evaluation. Those students who choose to undergo a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE) must have the appropriate person(s) complete the first four Sections of the CIPPE Form. Upon completion of Sections 1, 2, and 3 by the parent/guardian, and Section 4 by an Authorized Medical Examiner, 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 shall be performed no earlier than June 1st and shall be effective, regardless of when performed during a school year, until the next May 31st.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: A student completing a CIPPE, and seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 5 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, of the student's school will then determine whether Section 6 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student's Name _____ Age _____ Grade _____

Current Physical Address _____

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

EMERGENCY INFORMATION

Primary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Telephone # () _____

Family Physician's Name _____, MD or DO (circle one)

Address _____ Telephone # () _____

Student's Allergies _____

Student's Health Condition(s) of Which an Emergency Physician Should be Aware _____

Student's Prescription Medications _____

SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

The student's parent/guardian must complete all parts of this form.

A. I hereby give my consent for _____ born on _____ who turned _____ on his/her last birthday, a student of _____ School and a resident of the _____ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____ - 20____ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

Sport	Signature of Parent or Guardian
Baseball (Spring)	
Basketball (Winter)	
Bowling (Winter)	
Cross Country (Fall)	
Field Hockey (Fall)	
Football (Fall)	
Golf (Fall)	
Gymnastics (Winter)	
Lacrosse (Spring)	
Rifle (Winter)	
Soccer (Fall)	
Soccer-Girls (Spring)	
Softball (Spring)	
Swimming & Diving	
Tennis-Girls (Fall)	
Tennis-Boys (Spring)	
Track-Indoor (Winter)	
Track & Field (Spring)	
Volleyball-Girls (Fall)	
Volleyball-Boys (Spring)	
Water Polo (Fall)	
Wrestling (Winter)	
Other	

B. **Understanding of eligibility rules:** I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

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

C. **Disclosure of records needed to determine eligibility:** To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

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

D. **Permission to use name, likeness, and athletic information:** I consent to PIAA's use of the herein named student's name, likeness, and athletically related information in reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

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

E. **Permission to administer emergency medical care:** I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care.

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

SECTION 3: HEALTH HISTORY

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

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	23. Has a doctor every told you that you have asthma or allergies?	<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"/>	24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	<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"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats 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"/>
9. Has a doctor ever told you that you have (check all that apply):			30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur			31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been unable to move your arms or legs after being hit or failing?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or Contest? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<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"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<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"/>	42. Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
			43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
			44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
			45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
			46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
			FEMALES ONLY		
			47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
			48. How old were you when you had your first menstrual period?	_____	
			49. How many periods have you had in the last 12 months?	_____	
			50. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

No(s).	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date ____/____/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

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

**SECTION 4: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION
AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER**

Must be completed and signed by the Authorized Medical Examiner performing the herein named student's comprehensive initial pre-participation physical evaluation 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) _____ Pulse _____ BP _____/_____/_____ (_____/_____, ____/____)

Vision R 20/____ L 20/____ Corrected YES NO (circle one) Pupils: Equal _____ Unequal _____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

CLEARED **CLEARED**, with recommendation(s) for further evaluation or treatment for: _____

NOT CLEARED for the following types of sports (please check those that apply):

COLLISION CONTACT NON-CONTACT STRENUOUS MODERATELY STRENUOUS NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

Authorized Medical Examiner's Name (print/type) _____ License # _____

Address _____ Phone () _____

Authorized Medical Examiner's Signature _____ MD, DO, PAC, CRNP, or SNP (circle one) Date ___/___/___

SECTION 5: PIAA RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed by the parent/guardian of any student who (1) previously participated in PIAA interscholastic athletic competition pursuant to a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year. The Principal, or Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY and make a determination as to whether the student should be re-evaluated and re-certified by an Authorized Medical Examiner pursuant to Section 6.

SUPPLEMENTAL HEALTH HISTORY

Student's Name _____ Age _____ Grade _____

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):

Primary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Telephone # () _____

Family Physician's Name _____, MD or DO (circle one)

Address _____ Telephone # () _____

SUPPLEMENTAL HEALTH HISTORY:

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

	Yes	No		Yes	No
1. Have you sustained an illness and/or injury related to sport(s) since completion of the CIPPE?	<input type="checkbox"/>	<input type="checkbox"/>	5. Have you experienced dizzy spells, blackouts, and/or unconsciousness?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you sustained an illness and/or injury NOT related to sport(s) since completion of the CIPPE?	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been confined to an institution and/or at home as a result of an illness and/or injury since completion of the CIPPE?	<input type="checkbox"/>	<input type="checkbox"/>	7. Have you experienced any new health problems since completion of the CIPPE?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had surgery since completion of the CIPPE?	<input type="checkbox"/>	<input type="checkbox"/>	8. Are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills since completion of the CIPPE?	<input type="checkbox"/>	<input type="checkbox"/>
			9. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

No(s).	Explain "Yes" answers here:

SUBSEQUENT SPORT(S) TO BE PLAYED: _____ **SEASON:** Fall Winter Spring (circle one)

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 ____/____/____

NOTE: If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the Principal, or Principal's designee, of the herein named student's school shall require the student to complete Section 6 prior to being eligible to participate in sport(s) identified above.

Section 6: PIAA COMPREHENSIVE PRE-PARTICIPATION PHYSICAL RE-EVALUATION AND RE-CERTIFICATION BY AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by an Authorized Medical Examiner and turned in to the Principal, or the Principal's designee, of the student's school prior to participation in second and subsequent sport in the same school year.

Student's Name _____ Age _____ Grade _____

Enrolled in _____ School Sport(s) _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____/_____/_____ (_____/_____, ____/____)

Vision R 20/____ L 20/____ Corrected YES NO (circle one) Pupils: Equal _____ Unequal _____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the SUPPLEMENTAL HEALTH HISTORY, performed a physical re-evaluation of the herein named student, and, on the basis of such re-evaluation and the student's SUPPLEMENTAL 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 5 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) _____

Authorized Medical Examiner's Name (print/type) _____ License # _____

Address _____ Phone () _____

Authorized Medical Examiner's Signature _____ MD, DO, PAC, CRNP, or SNP (circle one) Date ___/___/___

Section 7: CIPPE MINIMUM WRESTLING WEIGHT CLASSIFICATION

INSTRUCTIONS

Pursuant to the Weight Control Program adopted by PIAA, prior to the participation by any student in interscholastic wrestling, the minimum weight classification at which the student may wrestle during the season must be (1) certified to by an Authorized Medical Examiner, 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. This certification shall be provided to and maintained by the student's Principal, or the Principal's designee.

In certifying to the minimum weight classification, the Authorized Medical Examiner 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, Scholastic Edition (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 Authorized Medical Examiner may require that the student wrestle at a minimum weight classification one or more weight classifications above what would otherwise be appropriate based upon the student's Minimum Wrestling Weight, as established by the Initial Assessment. Under these circumstances, the Authorized Medical Examiner may NOT allow a wrestler to participate at a minimum weight classification below that determined by the Initial Assessment.

For all wrestlers, the certified minimum wrestling weight class shall be certified to by an Authorized Medical Examiner. The Authorized Medical Examiner shall initial the minimum wrestling weight class, pursuant to the Initial Assessment.

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 Optimal Performance Calculator, Scholastic Edition, and have determined as follows:

Urine Specific Gravity/Body Weight _____ / _____ Percentage of Body Fat _____ Minimum Wrestling Weight _____

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 allowed to wrestle at the following minimum weight classification during the 20____ - 20____ wrestling season (**the Authorized Medical Examiner may initial only one of the following senior high or junior high/middle school weight classes**):

SENIOR HIGH SCHOOL (14 Weight Classifications):

103 lbs. _____ 112 lbs. _____ 119 lbs. _____ 125 lbs. _____ 130 lbs. _____ 135 lbs. _____ 140 lbs. _____
145 lbs. _____ 152 lbs. _____ 160 lbs. _____ 171 lbs. _____ 189 lbs. _____ 215 lbs. _____ 285 lbs. _____

JUNIOR HIGH/MIDDLE SCHOOL (18 Weight Classifications):

75 lbs. ____ 80 lbs. ____ 85 lbs. ____ 90 lbs. ____ 95 lbs. ____ 100 lbs. ____ 105 lbs. ____ 110 lbs. ____ 115 lbs. ____
122 lbs. ____ 130 lbs. ____ 138 lbs. ____ 145 lbs. ____ 155 lbs. ____ 165 lbs. ____ 185 lbs. ____ 210 lbs. ____ 250 lbs. ____

Authorized Medical Examiner's Name (print/type) _____ License # _____

Address _____ Phone () _____

Authorized Medical Examiner's Signature _____ MD, DO, PAC, CRNP, or SNP Date ____ / ____ / ____
(circle one)

NOTE: Any athlete who disagrees with the Initial Assessment may appeal the assessment results one time by having a second assessment performed. The second assessment must utilize either Air Displacement Plethysmography (Bod Pod) or Hydrostatic Weighing testing to determine body fat percentage. Results obtained at the second assessment shall supersede the Initial Assessment and are automatically accepted; no further appeal by any party is permitted. All costs incurred in the second assessment are the responsibility of those appealing the Initial Assessment. The urine specific gravity testing will be conducted and the athlete will need to have a result of less than or equal to 1.025 in order for the second assessment to proceed.

SPORT _____

Return completed form to your Coach

DIOCESE OF PITTSBURGH
PROTECTED INSURANCE PLAN

REQUEST FOR MEDICAL COVERAGE INFORMATION
FORM "A"

Participating Student _____

Mother's Name _____ S.S. No. _____

Father's Name _____ S.S. No. _____

Mother's Employer: _____ Employer's Address: _____

Phone: _____

Father's Employer: _____ Employer's Address: _____

Phone: _____

Hospitalization Blue Blue Major Group No. _____
Covering Athletes: Cross _____ Shield _____ Medical _____ I.D. No. _____

Other Policy I.D.
Coverage _____ Number _____ Number _____

Proof of medical coverage is required for an athlete to participate in sports. If no coverage exists, the student **CANNOT** participate in athletics.

A parent permitting a student to participate in school athletics after coverage has terminated or without coverage will assume full responsibility for any medical claim resulting from an injury while participating in the sport.

It must be understood that coverage for injury resulting from athletic participation is specifically excluded from the Diocesan Insurance Programs. It is for this reason that the preceding paragraphs must be strictly adhered to.

I/We, the undersigned, do attest to the accuracy of the information provided on this form. Furthermore, should there be a change, the school, the school principal and coach will be notified immediately of any change.

Parent or Guardian's Signature

Parent or Guardian's Signature

Approved: _____
(Principal)

SPORT _____

RELEASE FORM

SCHOOL: Central Catholic High School
4720 Fifth Avenue
Pittsburgh, PA 15213
(412) 621-8189

PHYSICIAN RELEASE

_____ has been examined by me on _____
(Name of Student) (Date)

and my examination has found no medical reason to preclude his participation in competitive sports.

_____ (Physician) _____ (Date)

PARENTS' RELEASE

In consideration of _____ being allowed to participate in
(Son's Name)
competitive sports, and intending to be legally bound, I do hereby release and forever discharge the Roman Catholic Diocese of Pittsburgh, the Bishop of the Diocese, Catholic Institute, and Central Catholic High School of the City of Pittsburgh, and/or the School Athletic Association, their agents and their successors, from any/all actions or suits in law or equity which I/We might hereafter have, by reason of injuries sustained by my child participating in sports or in transit to or from participation in sports.

Parents' or Guardians' Signatures

_____ (Father's Signature)

_____ (Mother's Signature)

_____ (Date)

_____ (Date)