



UNION HIGH SCHOOL

"Home of the Golden Knights and Damsels"

354 Baker Street, Suite 1
Phone: 814-473-3121

Rimersburg, PA 16248-9211
www.unionsd.net

Information for all Union Athletes for the 2024-2025 School Year.

In order to prepare for the 2024-2025 school year, the Pennsylvania Interscholastic Athletic Association (PIAA) requires that students must complete a comprehensive initial pre-participation physical evaluation (CIPPE), performed by an Authorized Medical Examiner before your first sport season's first practice of the school year. The physicals are for any students grade 7th - 12th that are planning on participating in any sports listed in Section 2 of the packet. Students will only need one sports physical per school year. The physical will be good through the end of the spring sport season. The exception would be if your student athlete becomes injured or ill.

We will be offering physicals **JUNE 7th 2024, 8:00 AM – 2:00 PM**. The physicals will be held in the nurse's office at the high school. Students will be sent a google form via school email to sign up. Time slots will be assigned in order of sign up. Students will receive an email with their time once the packet has been turned into the high school office. Parents are invited to be present. Physicals will be done at no cost to you. If you do not receive a physical through the school you are responsible for having a physical completed through your own doctor.

Your child will not be able to participate in any sport (including open gyms and workouts) until he/she receives a current PIAA physical.

THE ATTACHED PACKET OF FORMS MUST BE COMPLETED AND TURNED INTO THE HIGH SCHOOL OFFICE BY May 20th 2024, IF YOUR STUDENT IS HAVING THE PHYSICAL COMPLETED AT UNION .

The parent or guardian and student must sign all forms. If all forms are not completed and presented to the Athletic Trainer, the student will not be able to participate until they have been completed. *PIAA physicals can not be dated prior to May 1st and must be signed by a MD,DO, PAC, CRNP, or SNP licensed in the state of Pennsylvania.*

Sincerely,

Heather Clover-Bair, LAT, ATC, ITAT, EMT
Head Athletic Trainer
Office: 814-473-3121 x1142
E-mail: cloverhj@unionsd.net

The Following Forms Must be Completed:

Pennsylvania Interscholastic Athletic Association (PIAA):

Section 1: Personal and Emergency Information

Section 2: Certification of Parent/Guardian

Section 3: Understanding of Risk of Concussion and Traumatic Brain Injury

Section 4: Understanding of sudden Cardiac Arrest Symptoms and Warning Signs

Section 5: Health History

Section 6: PIAA Comprehensive Initial Pre-Participation Physical Examination and Certification of Authorized Medical Examiner

Union Required Portion:

Concussion Protocol

Section 1: Acknowledgment of Risk and Consent Form

Section 2: Impact Testing Consent Form, Athletic Treatment Authorization

Section 3: Football helmet and All Sports Warning Forms

Section 4: Union School District Drug and Alcohol Testing Authorization

Not included in this packet, but additional forms you need to be aware of:

Section 7: Re-Certification by Parent/Guardian (PIAA)

Section 8: Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine (PIAA)

2021-2022 Sports Include:

- Varsity / Junior Varsity Football
- Junior High Football
- Varsity / Junior Varsity Volleyball
- Junior High Volleyball
- Varsity / Junior Varsity Football Cheerleading
- Junior High Football Cheerleading
- Junior High/ Varsity Cross Country
 - Varsity Golf
- Junior High Girls' basketball
- Junior High Boys' Basketball
- Varsity/Junior Varsity Boys' Basketball
- Varsity / Junior Varsity Girls' Basketball
- Varsity/Junior Varsity Wrestling
- Junior High Wrestling
- Varsity / Junior Varsity Baseball
- Varsity / Junior Varsity Softball
- Varsity / Junior Varsity Track
- Junior High Track
- Junior High / Varsity Swimming



**PIAA COMPREHENSIVE INITIAL
PRE-PARTICIPATION PHYSICAL EVALUATION**



INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than May 1st and shall be effective, regardless of when performed during a school year, until the latter of the next April 30th or the conclusion of the spring sports season.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 7 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will then determine whether Section 8 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

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

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 _____ School who turned _____ on his/her last birthday, a student of _____ public school district, and a resident of the _____ 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 off physical exhaustion. If the conditions that cause SCA are diagnosed and treated before a life-threatening event, sudden cardiac death can be prevented in many young athletes.

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

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

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

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

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

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

What is an electrocardiogram (EKG or ECG)?

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

Why add an ECG/EKG to the physical examination?

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

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

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

Removal from play/return to play

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

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

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

Date ____/____/____

Signature of Student-Athlete

Print Student-Athlete's Name

Date ____/____/____

Signature of Parent/Guardian

Print Parent/Guardian's Name

SECTION 5: HEALTH HISTORY

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

- | | | | | | | | |
|---|--------------------------|--------------------------|-----------|-------|-----------|---------------|------------|
| | Yes | No | | | | | |
| 1. Has a doctor ever denied or restricted your participation in sport(s) for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 2. Do you have an ongoing medical condition (like asthma or diabetes)? | <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"/> | | | | | |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <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"/> | | | | | |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 9. Has a doctor ever told you that you have (check all that apply): | | | | | | | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| <input type="checkbox"/> Heart infection | <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"/> | | | | | |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 12. Does anyone in your family have a heart problem? | <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"/> | | | | | |
| 14. Does anyone in your family have Marfan Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 16. Have you ever had surgery? | <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"/> | | | | | |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | <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"/> | | | | | |
| Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand/ Fingers | Chest |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/ Toes |
| 20. Have you ever had a stress fracture? | <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"/> | | | | | |
| 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 23. Has a doctor ever told you that you have asthma or allergies? | <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"/> |
| 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine? | <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"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you ever had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |

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"/> |
| 34. Have you ever had a seizure? | <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"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling? | <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"/> |
| 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"/> |
| 39. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses? | <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"/> |
| 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"/> |
| MENSTRUAL QUESTIONS- IF APPLICABLE | | |
| 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. When was your last menstrual period? | _____ | _____ |

#'s	Explain "Yes" answers here:

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

Student's Signature _____ Date ____/____/____

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

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

**SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION
AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER**

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name _____ Age _____ Grade _____

Enrolled in _____ School Sport(s) _____

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

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.

Age 10-12: BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

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

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		<input type="checkbox"/> Heart murmur <input type="checkbox"/> Femoral pulses to exclude aortic coarctation <input type="checkbox"/> Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

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

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

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

COLLISION CONTACT NON-CONTACT STRENUOUS MODERATELY STRENUOUS NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type) _____ License # _____

Address _____ Phone () _____

AME's Signature _____ MD, DO, PAC, CRNP, or SNP (circle one) Certification Date of CIPPE ____/____/____

ACKNOWLEDGEMENT OF RISK AND CONSENT STATEMENT

I, a Union School District student-athlete and parent/guardian of a student-athlete understand that:

- | STUDENT | PARENT | |
|------------------|------------------|--|
| _____
Initial | _____
Initial | a. Participation in athletics includes a risk of injury which may range from minor to long-term catastrophic or death, and I acknowledge and accept these inherit risks. |
| _____
Initial | _____
Initial | b. I must refrain from practice or play while ill or injured until cleared by appropriate medical personnel and/or their designated representative (Certified Athletic Trainer) whether receiving medical treatment or not. |
| _____
Initial | _____
Initial | c. Having passed the sports participation physical examination does not necessarily mean that I am physically qualified to participate in athletics, but only that the examiner did not find a medical reason for disqualification from participation. |
| Parent only | _____
Initial | d. I consent to have my son/daughter represent Union School District in approved athletic activities. I agree not to hold the school district or anyone acting on its behalf responsible for any injury occurring to my son/daughter in the proper course of such athletic activities or travel. |

Participants have the responsibility to help reduce the chance of injury. Participants must obey all safety rules and regulations, report all physical problems to the coach or Certified Athletic Trainer, follow a proper conditioning program, and inspect personal protective equipment daily. Proper execution of skill techniques must be followed for every sport, especially in contact/collision sports.

Parent/Guardian

____/____/____
Date

Student-Athlete Signature

____/____/____
Date

Student Athlete Release to be Tested With ImPACT Concussion Assessment Software

Athletes may not understand the potential consequences of concussion and often minimize or deny symptoms so they can return to play. As a result, repeated concussions, from returning to sport too early, can cause symptoms to have a cumulative effect. Given such concerns, ranging from mild to catastrophic and the inherent difficulties in managing concussion, individualized and comprehensive management of concussion is optimal. At the forefront of proper concussion management is the implementation of baseline and/or post-injury neurocognitive testing. Such evaluation can help to objectively evaluate the concussed athlete's post-injury condition and track recovery for safe return to play, thus preventing the cumulative effects of concussion.

ImPACT is a user-friendly, Windows based computer program specifically designed for the management of sport related concussion. ImPACT takes approximately 20 minutes to complete. The computer program measures multiple aspects of cognitive function in the athlete. ImPACT is currently the most widely utilized program in the world and is implemented effectively across high school, collegiate and professional levels of sport participation.

Your child will be baseline tested before the first practice of their first sport during the school year. If your child suffers a blow to the head or whiplash type injury during sport or gym-class participation, the athletic trainer will evaluate them clinically and with the ImPACT software. If the post-injury values reported by ImPACT fall outside an allowed deviation from the base-line values your child will be referred to their family physician or a specialist for further evaluation. If your child does indeed have a concussion they will be continually monitored by the ImPACT program to make a safe and objective decision on their return to sport participation. The doctor will have the final say in the release of your child to return to sport participation.

I _____ give permission to Union High School to perform ImPACT
(parent/guardian name)
concussion assessment testing on my son/daughter _____ to attain
(student athlete name)
baseline and post-injury values in the event a head injury may occur.

Athletic Trainer Treatment Authorization

I/We give permission to the NATA certified athletic trainer employed by Union School District to perform immediate care and emergency treatment to injuries incurred during any interscholastic or intramural activity in this school district, and if necessary, to transport him/her to the nearest medical facility. Parents further acknowledge that the Certified Athletic Trainer may contact the student's physician in order to obtain information concerning the extent of injuries sustained, the extent to which a student may participate in the sport, and what additional treatment the physician may want the athletic trainer to perform. Information obtained by the athletic trainer will be considered confidential and will be treated as such. By signing this form, the parent acknowledges the risks involved and understands that the school district, officials, coaches and/or athletic trainer will not be held responsible for any injury or damage. The parent/guardian must assume full responsibility for any injury or damage to his/her child through his/her hospital or insurance plan. If the parent does not sign this form, his/her child will not be permitted to participate in interscholastic or intramural activities.

I/We _____, _____ have read and understand
(Parent/guardian) (Parent/guardian)
all the above information fully and give full consent as stated above to my child to participate in interscholastic/intramural activities at Union High School.

_____ Date _____ Student Athlete Signature

Treatment Authorization

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, as a member of the Pennsylvania Interscholastic Athletic Association (PIAA), Union School District requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/PIAA, to the extent the QMP deems necessary to prevent harm to the student/athlete. It is understood that a QMP may be an athletic trainer, physician, physician assistant or nurse practitioner licensed by the state of Pennsylvania (or the state in which the student/athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by Pennsylvania law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designated by state regulation and standing protocols, and not for the purpose of making decisions about return to play.

PLEASE PRINT LEGIBLY:

"I, _____ (Parent/ legal guardian's name), the undersigned, am the parent/legal guardian of, _____ (Student's Name), a minor and student/athlete at Union School District who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/PIAA employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the

designated state license, except as otherwise limited by Pennsylvania law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student/athlete's recovery and safe return to activity, and any treating QMP. If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/PIAA.

Date: _____ Parent Signature _____

CONCUSSION PROTOCOL

The purpose of this protocol is to educate and minimize the risks and potential injury that can be sustained during athletic activities. *The health and welfare of the student-athlete will be the primary consideration throughout this protocol.*

Definition of Sports Concussion

"Sports concussion is defined as a complex pathophysiological process affecting the brain, induced by traumatic biomechanical forces." (Concussion in Sports Group, Vienna 2001, *Clic J Sports Med*, 12:6-11, 2002).

1. Concussions may be caused by a direct blow to the head, face, neck or elsewhere on the body with an "impulsive" force transmitted to the head.
2. Concussions typically result in the rapid onset of short-lived impairment of neurological function that resolves spontaneously.
3. Concussions may result in neuropathological changes, but the acute clinical symptoms largely reflect a functional disturbance rather than structural injury.
4. Concussions result in a graded set of clinical syndromes that may or may not involve loss of consciousness. Resolution of the clinical and cognitive symptoms typically follows a sequential course.

Signs and Symptoms

If a student-athlete has received head trauma, the next step is recognizing whether a concussion is present. A concussion will be suspected if any student-athlete presents with one or more of the below signs or symptoms after sustained direct or indirect contact with the head. In accordance with the Safety in Youth Sports Act (effective July 2012), a student-athlete that "exhibits signs or symptoms of a concussion or traumatic brain injury while participating in an athletic activity shall be removed by the coach from participation at that time." These signs or symptoms may be noticed by a game official, coach from the student-athlete's team, the Certified Athletic Trainer or a licensed physician and the athlete *must* be removed from participation. The Act also states, "The coach shall not return a student to participation until the student is evaluated and cleared for return to participation by an appropriate medical professional." If a concussion is suspected, the student-athlete will not return to participation the same day of injury.

The following is a list of possible signs or symptoms of a concussion or traumatic head injury. This list is not an all-inclusive list, other signs or symptoms may occur that are not listed below.

- Headache
- Nervous or anxiety
- "Pressure" in the head
- Trouble falling asleep
- Neck pain
- Sleeping more than usual
- Balance problems/dizzy
- Drowsiness
- Nausea or vomiting
- Fatigue
- Vision problems
- More emotional than usual
- Feeling like in a "fog"
- Slurred speech
- Convulsions or seizures
- Irritability
- Feeling dazed
- Hearing problems/ringing in ear(s)
- Sadness
- Confusion
- Sensitivity to light
- Sensitivity to noise
- Feeling slowed down
- Don't feel right
- Difficulty concentrating

A student-athlete that presents with any of the aforementioned signs or symptoms will be removed from play and monitored. They will be referred to the emergency room immediately if their condition drastically worsens or if they present with any of the following signs or symptoms:

- Deterioration of neurological function
- Decreasing level of consciousness
- Irregularity in respirations
- Irregularity in pulse
- Unequal, dilated, or unreactive pupils
- Any signs or symptoms of associated injury; i.e., spine or skull fracture
- Mental status change: lethargy, difficulty maintaining arousal, confusion or agitation
- Seizure activity
- Loss of consciousness
- Cranial deficits
- Vomiting

If a student-athlete is not referred to the emergency room, the parent/guardian will be notified of the injury and the student-athlete will be given take-home instructions to follow. The student-athlete must see the Certified Athletic Trainer the following day and every day thereafter until cleared to return-to-play by an appropriate medical professional.

Return to Play Guidelines

Once a student-athlete has displayed any of the signs or symptoms stated above resulting from direct or indirect contact to the head, the student-athlete will not return-to-play until they have been cleared by an appropriate medical professional. During this process, the student-athlete will be retested on IMPACT 48-72 hours post-injury. The student will not begin any physical exertion until their IMPACT test results have returned to their baseline and they have been

symptom free for 24 hours. Once ImPACT test results have returned to baseline and the student-athlete has remained symptom-free for 24 hours after the last ImPACT test, they may begin Physical Exertional Testing. The student-athlete must remain symptom free during the entire Physical Exertional Testing period. If they experience any signs or symptoms at any step, they must stop activity and cannot begin again until symptom-free for 24 hours once again. When they do start the testing, they will begin at the previous step they left off on.

- Step 1:** Aerobic exercise
- Step 2:** Sport-specific exercise
- Step 3:** Non-contact drills
- Step 4:** Controlled contact drill
- Step 5:** Full-contact
- Step 6:** Competition

Please note that some the above steps may be combined depending upon the severity of the student-athlete's concussion. There will, however, be a minimum of three days of Physical Exertional Testing before the athlete will be cleared for full return-to-play without any restrictions.

FOOTBALL ONLY!!
HELMET RELEASE FORM

As an athlete, you are entitled to know that your helmet is a piece of equipment which must be used in a proper manner. You must understand that the helmet is a protective device and not a weapon.

Do not strike an opponent with any part of this helmet or face mask. This is a violation of football rules and may cause you to suffer severe brain or neck injury, including paralysis or death. Severe brain or neck injury may also occur accidentally while playing football. No helmet can prevent all such injuries. Use **this helmet at your own risk.**

ATHLETE'S RESPONSIBILITY

Along with regular daily use of this helmet, you are also responsible for daily maintenance checks. These daily maintenance checks will help you to ensure the safety of your helmet and provide you with the best protection for you.

1. Upon daily inspection of your helmet, if you notice any parts loose or missing, you are responsible for reporting it to the head coach or athletic trainer immediately.
2. You must wear a mouth piece and chin strap at all times while using this helmet.

I have read and understand all instructions for the use of a football helmet.

Athlete's Name

Athlete's Signature

Parent or Guardian Signature

UNION
SCHOOL DISTRICT

SECTION: PUPILS
TITLE: DRUG/ALCOHOL TESTING FOR
CO-CURRICULAR ACTIVITY (IES)
PARTICIPATION, DRIVING AND
PARKING PERMIT PRIVILEGES

ADOPTED: May 15, 2008
REVISED:

227.1 DRUG/ALCOHOL TESTING FOR CO-CURRICULAR ACTIVITY (IES)
PARTICIPATION, DRIVING, AND PARKING PERMIT PRIVILEGES

1. Purpose The Union School District considers participation in a co-curricular program, driving to school and the issuance of parking permits for parking upon school property to be privileges and voluntary activities. As representatives of the school district and leaders in their schools, students involved in co-curricular programs and students who drive to school are expected to exemplify high standards by the public and are held in high esteem by other students. Participants in co-curricular programs and those who drive to school are expected to accept the responsibilities accompanying these opportunities.

Deterring drug use by school students is important. School years are the time when physical, psychological and addictive effects of drugs are most severe. The effects of a drug-infested school are visited not just upon the users, but upon the entire student body and faculty because the educational process is disrupted.

With regard to school athletes and student drivers, the risk of immediate physical harm to the drug and alcohol user or those with who s/he is playing a sport or sharing the highway is particularly high. Apart from psychological effects, which include impairment of judgment, slowing of reaction time, and a lessening of the perception of pain, alcohol and the particular drugs screened by this policy pose substantial physical risks to athletes and drivers. Co-curricular participants, whether athletes or not, are student leaders and, as such, serve as role models for their peers and for young children as well. The use of drugs and alcohol by these role models exacerbates the problem of illegal substances in our schools.

The purpose of this policy is:

1. To prevent student participants in co-curricular programs and students with driving privileges from using drugs.
2. To protect the health and safety of students.
3. To prevent accidents and injuries, resulting from the use of alcohol or controlled substances.
4. To provide drug and alcohol users with assistance programs.

227.1 DRUG/ALCOHOL TESTING FOR CO-CURRICULAR PARTICIPATION, DRIVING AND PARKING PERMIT PRIVILEGES

Authority Individualized searches of public school students conducted by school officials are subject to a reasonable suspicion standard under Article 1, Section 8 of the Pennsylvania Constitution.

Commonwealth v. J.B., 719 A.2d

Page 1058;

Jersey

v.T.L.O.,

U.S. 325,

105 S. Ct. 733,

83 L.Ed.2d 720;

and Commonwealth

v. Cass, 709

A.2d 350

Futher, the adoption of a reasonable suspicion standard for individualized school searches New under our state constitution does not undermine the emotional development of students, to the contrary, such standards promote the well being of the youth of the Commonwealth. 469 First and foremost, this standard demonstrates to students that the law recognizes they have a legitimate privacy interest while attending school, however, it also reminds them that no rights are without limit.

Alcohol, drugs and violence detrimentally affect the safety, security and education of Pennsylvania school students. Consequently, any privacy interest which a student has or may expect must be balanced against the need to maintain order and diplomacy in school. The adoption of reasonable suspicion standards signals to students that the law of the Commonwealth will not tolerate the presence of drugs, alcohol or weapons on school property.

SC 510

This policy is adopted in accordance with the authority granted to School Boards, permitting School Boards to adopt reasonable rules and regulations regarding the management of school district affairs and the conduct and deportment of all students during the time that they are under the supervision of the Board of School Directors and teachers, including the time necessarily spent coming to and returning from school.

3. Guidelines

Requirements

No member of a co-curricular program and no student who has been given permission by the school officials to drive to school and has been issued a school parking permit shall have a breath alcohol concentration of 0.02 or higher, and no student who has been given permission by school officials to drive to school and has been issued a school parking permit shall use any controlled substance, as verified by the testing of a urine sample. Co-curricular students shall notify the sponsor of their co-curricular program if they are taking any therapeutic drugs and shall supply a written certification from the physician prescribing the drug that the substance will not adversely affect the student's ability to safely and effectively participate in the co-curricular program. Student drivers shall provide the same notice and documentation to the school principal.

No student shall refuse to submit to an alcohol or controlled substances test required under this policy. Such refusal includes, by way of example and not limitation:

1. A student's failure to provide adequate breath for testing without a valid medical explanation after s/he has received notice of the requirement for breath testing in accordance with this policy..
2. A student's failure to provide adequate urine for controlled substances testing without a valid medical explanation after s/he has received notice of the requirement for urine testing in accordance with this policy.
3. A student's conduct that clearly obstructs the testing process. Any attempt by a student to adulterate a sample shall be treated as conduct that clearly obstructs the testing process.

227.1 DRUG/ALCOHOL TESTING FOR CO-CURRICULAR PARTICIPATION, DRIVING AND PARKING PERMIT PRIVILEGES

Testing shall take place when the student is at school, when the student is participating in the co-curricular program, or otherwise as designated by this policy.

Scope

This policy shall apply to students participating in co-curricular programs in the district's secondary schools, middle schools, high schools and voluntary at the elementary grades, and those who have been given permission by school officials to drive to school and/or have been issued a parking permit. Co-curricular participation shall include all interscholastic athletics, clubs, and other activities in which students participate on a voluntary basis and for which credit is not awarded toward meeting graduation requirements. A list of the co-curricular activities in a school shall be available from the principal.

There shall be four (4) types of tests: random testing; reasonable-suspension testing; return-to-activity testing; and follow-up testing.

Random testing shall be conducted on a monthly basis for the co-curricular and driving students. The students selected for testing shall be chosen at random. Selection shall be by a scientifically valid method. Each student shall have an equal chance to be selected with each random sampling. Random testing shall be unannounced and spread reasonably throughout the year. When the student is notified that s/he has been selected, the student shall proceed to the test site immediately.

Reasonable-suspicion testing shall be conducted when the sponsor of the co-curricular activity or Student Assistance Program team member has reasonable suspicion that a co-curricular student or student with driving privileges and/or a school parking permit is using or has used alcohol or controlled substances in violation of this policy. Reasonable suspicion shall be based on specific, contemporaneous, articulable observations of appearance, behavior, speech or body odors when the student is at school, at a school-sponsored event, or taking part in the co-curricular program. The alcohol test shall be conducted as soon as possible after observation, but no more that eight (8) hours after observation. If the test is not conducted within two (2) hours of the observation, records shall be kept stating why the testing was not performed within two (2) hours. A written record of observations shall be made and, in the case of controlled substance testing, the report shall be made within twenty-four (24) hours or before the release of the test results, whichever is earlier.

Reasonable-suspicion will include students not participating in an activity and will include students in grades 4-12.

Return-to-activity testing shall be required before a student is allowed to return to participation in a co-curricular activity or to resume driving to school after having violated any of the prohibitions in this policy relating to drug and alcohol use. The alcohol test shall show a result of less than 0.02 in order to for the student to return to the co-curricular activity or to resume driving privileges. A controlled substances test shall be negative. (See section on Consequences for Violating Drug/Alcohol Policy or Testing "Positive" and Offenses).

227.1 DRUG/ALCOHOL TESTING FOR CO-CURRICULAR PARTICIPATION, DRIVING AND PARKING PERMIT PRIVILEGES

Follow-up testing shall be required when any co-curricular student or student with driving privileges is in need of assistance in resolving problems associated with the use of alcohol and/or controlled substances as determined by a substance abuse professional, and shall be subject to unannounced testing as directed by the substance abuse professional. When required, a student may be tested a number of times. (See section on Consequences for Violating Drug/Alcohol Policy or Testing "Positive" and Offenses).

Procedures

As a prerequisite for joining and becoming a member of a co-curricular program and for the privilege of driving to school and/or obtaining a school parking permit, a student shall consent to testing for alcohol and controlled substances. Prior to admittance to each co-curricular program and to the receipt of driving privileges in a school year, a contract shall be signed authorizing the school district to collect urine, and breath samples. The contract shall be signed by a parent/guardian of a student. A contract shall be in effect for only (1) school year.

Testing shall be conducted according to established protocol. Breath alcohol testing shall be conducted by a certified Breath Alcohol Technician using an instrument approved by the National Highway Safety Administration as an evidential breath testing device. A breath alcohol concentration of 0.02 or higher shall be followed by a confirmation test at least fifteen (15) minutes after the screening test. Prior to conducting the confirmation test, the Breath Alcohol Technician shall obtain an air blank registering 0.000. Following the confirmation test, the student shall be given a printout of confirmation results, which shall be identified with unique, sequential confirmation test number.

Urine samples shall be collected by trained medical personnel in a manner that balances the values of privacy and confidentiality with the accuracy of the tests. Tests shall utilize the split sample method and a laboratory which follows procedures required by the Substance Abuse and Mental Health Service Administration. The laboratory's chain of custody procedures shall be followed. There shall be an initial screening test using an immunoassay test. All specimens identified as positive in the initial screening test shall then be subject to a confirmation test using a gas chromatography/mass spectrometry technique. If the confirmation test is positive, the results shall be submitted to a medical review officer. The medical review officer shall conduct a review of the test to determine the existence of possible alternative medical explanations for the positive results. This review may include a medical interview and review of the student's medical history, or review of other biomedical factors and medical records. The medical review officer shall give the student or the student's parent/guardian an opportunity to discuss a positive test result.

227.1 DRUG/ALCOHOL TESTING FOR CO-CURRICULAR PARTICIPATION, DRIVING AND PARKING PERMIT PRIVILEGES

When a medical review officer's services are used, the principal shall:

1. Make reasonable efforts to contact each student who submitted a specimen under this policy or the student's parent/guardian and to request that they discuss the results of the controlled substances test with the medical review officer who has been unable to reach the student or parent/guardian.
2. Notify the medical review officer within twenty-four (24) hours that the student or parent/guardian has been notified to contact the medical review officer. If the medical review officer believes that there is no adequate alternative explanation for the positive result, the positive result shall be reported to the Building Administrator, who shall forward the report to the student's principal. The test shall be reported as negative if a negative finding is found on the initial screening test, through the confirmation test, or through a determination by the medical review officer. Within three (3) days of notice of a positive result, the student or the student's parent/guardian may request a retest of the split sample that was retained.

In order to ensure the accuracy of the tests, samples shall be collected at the nurse's office within the school building. Specified control forms shall be utilized to ensure accurate identification of the sample and chain of custody. Techniques shall be adopted to prevent tampering. A certified laboratory shall be used for the tests.

Alcohol testing shall be conducted by a trained breath alcohol technician using an evidential breath testing device approved by the National Highway Traffic Safety Administration. Alcohol testing shall be conducted in a location selected for its visual and aural privacy for the student being tested. If a test result is 0.02 or higher, a confirmation test shall be performed at least fifteen (15) minutes later. The results of the confirmation test shall control whether the test is deemed positive or negative. The breath alcohol technician shall transmit all results to the school principal in a confidential manner.

All costs with the random testing shall be paid by the school district. The principal shall recommend the actions necessary to ensure that the school district can perform the testing described in this policy and has the services of a qualified medical review officer, a qualified substance abuse professional, and a certified laboratory. The testing lab will be instructed to test for one or more illegal drugs. Testing for controlled substances shall focus on a set of drugs selected by the school nurse in consultation with the secondary principals who shall decide which illegal drugs will be screened, but in no event shall that determination be made after selection of students for testing. Student's samples will not be screened for the presence of any substances other than an illegal drug or for the existence of any physical condition other than drug intoxication. An example of an appropriate set of drugs is the following group: marijuana; cocaine, to include crack; opiates, to include heroin and codeine; amphetamines, to include speed; phencyclidine, to include PCP and angel dust; barbiturates; benzodiazepines; methaqualone; methadone and propoxyphene. The results of the tests for alcohol and drugs shall be disclosed only to the student, his/her parents/guardians, and a limited class of school personnel who have a need to know; athletic director; the principal; the student assistance team; the substance abuse professional who works with the student; the guidance counselor, the coach and/or advisor; otherwise known as the implementation committee. These school representatives shall protect the confidentiality of test results.

227.1 DRUG/ALCOHOL TESTING FOR CO-CURRICULAR PARTICIPATION, DRIVING AND PARKING PERMIT PRIVILEGES

Penalties

If the student tests positive for alcohol or controlled substances, the following responses shall be activated:

1. The principal or his/her designee shall hold a parental conference to discuss the results of the testing.
2. The student shall participate in the student assistance program. The student shall participate in a drug/alcohol assessment with a certified drug and alcohol evaluator. Failure to comply with the evaluator's recommendations shall result in dismissal from co-curricular activities, the loss of driving privileges to school and forfeiture of school parking permit.

3. **Consequences for Violating the Drug/Alcohol Policy or Testing "Positive"**
No student participating in this testing program shall be penalized academically for testing positive for illegal drugs. The results of drug tests pursuant to this policy will not be documented in any students' academic records. Information regarding the results of drug tests will not be disclosed to criminal or juvenile authorities absent legal compulsion by valid and binding subpoena or other legal process, which the District shall not solicit in the event of service of any such subpoena or legal process, the student and the custodial parent or legal guardian will be notified at least 72 hours before response is made by the District.

The records of all students who tested negative will be destroyed at the end of the school year. Only the records of those students who tested positive and whose penalties transcend the school year into subsequent school years shall have their records maintained.

a. **First Offense**

The student participant will be suspended for 30 calendar days from the sport or activity(ies) and parking privileges. The student will also be referred to a licensed facility for drug assessment. Participation is contingency upon the student following through and complying with the facility's recommendation. The student will also be required to submit weekly urine specimens, via the Vendor, for five weeks. The expenses of the assessment and the five (5) weekly drugs tests will be incurred by the parent or guardian. The student will also be referred to the SAP team of the appropriate building and receive an appropriate educational program.

b. **The Second Offense Within a Six-Year Time Period**

The student participant will receive a suspension of both athletic or activity(ies) and driving privileges for one calendar year. The student will also be referred to a licensed facility for a drug assessment. Participation is contingent upon the student following through and complying with the facility's recommendation. The student will also be required to submit weekly urine specimens, via the Vendor, for five weeks. The expenses of the assessment and the five (5) weekly drug tests will be incurred by the parent or guardian. The student will also be referred to the SAP team of the appropriate building and receive an appropriate educational program.

227.1 DRUG/ALCOHOL TESTING FOR CO-CURRICULAR PARTICIPATION, DRIVING
AND PARKING PERMIT PRIVILEGES

c. **The Third Offense Within a Six-Year Time Period**

The student participant will receive a permanent suspension of driving privileges as well as a permanent suspension from any sport or activity(ies). The student will also be referred to a licensed facility for a drug assessment. The student will also be referred to the SAP team of the appropriate building.

4. If any co-curricular student or student with the driving privilege and/or a school parking permit at any time refuses to submit a urine or breath sample for testing in accordance with this policy, the refusal shall be treated as an offense. Any covered student who attempts to obstruct the testing process, for example by adulterating a sample, shall be treated as having received a positive test result.
5. Since the presence of any prohibited substance does not necessarily mean that the student was in possession or under the influence of such substance on school premises, such detection shall not result in suspension or expulsion from school. School district and school-based policies relating to the use, possession, or distribution of illegal substances on school premises, on school buses and at school-sponsored events shall remain unaffected by this policy.
6. No student shall be penalized academically for testing positive for alcohol or illegal drugs. The results of alcohol and drug tests pursuant to this policy will not be documented in any student's academic records. Information regarding the results of alcohol and drug tests will not be disclosed to criminal or juvenile authorities absent legal compulsion by valid and binding subpoena or other legal process, which the district shall not solicit. In the event of service of any such subpoena or legal process, the student and the student's custodial parent or legal guardian will be notified at least seventy-two (72) hours before response is made by the district.

Prohibition of Over-The-Counter Sports Enhancing Supplements

There exist several over-the-counter products known as sports enhancing supplements. The purpose of those supplements are to assist an athlete, enhance his/her overall physical development and some are designed to enhance a specific athletic event.

The Union School District wants to be clear in conveying the thought that the use of any supplement(s) or product(s) designed to enhance performance is not endorsed or condoned. It is our hope that parents will support our view that the use of such supplements should be prohibited.

As a means of conveying our opinions on the topic, our coaches, trainers and health teachers shall, through our curriculum and annual team orientations, address the issue with our students. The message we want to convey to our students is that preparation for athletic performance is best served through a proper and well-balanced nutritional diet and appropriate physical activity designed by our coaches, trainers and weight room supervisors.

UNION SCHOOL DISTRICT
354 BAKER ST., STE. 2
RIMERSBURG, PA 16248

DRUG AND ALCOHOL TESTING POLICY
GENERAL AUTHORIZATION FORM

I understand that my performance as a participant and the reputation of my school are dependent, in part, on my conduct as an individual. I hereby agree to accept and abide by the standards, rules, and regulations set forth by Union School District Policy #227.1 – Drug/Alcohol Testing for Co-Curricular Activity(ies) Participation, Driving and Parking Permit Privileges.

I also authorize Union School District to conduct a test on a urine or breath sample which I provide to test for drugs and/or alcohol use. I also authorize the release of information concerning the results of such a test to the Union School District and to the parents and/or guardians of the student.

This shall be deemed a consent pursuant to the Family Education Right to Privacy Act for the release of above information to the parties named above.

Student Signature

Date

Parent or Guardian Signature

Date