



24-25 Athletic Participation Documents and Forms Checklist

The following items are included in the packet and all are required to be completed prior to participation in any extracurricular activity.

- 1. PIAA Comprehensive Initial Pre Participation Physical Evaluation** (10 pages)-Completed by a Physician of your choice or for a \$20 fee during the summer held at Canton High School.
- 2. PIAA Emergency Card for Athletes** (1 page)
- 3. UPMC Authorization for Release of Protected Health Information** (2 pages)
- 4. CHS Medical Insurance-Acknowledgement of Coverage** (1 page)
- 5. Canton High School Athletic, Extra & Co-Curricular Code of Conduct** (6 pages)

CANTON AREA SCHOOL DISTRICT

“WARRIOR PRIDE”

ADMINISTRATIVE OFFICES

509 East Main Street - Canton, PA 17724
Ph: (570) 673-3191 Fax: (570) 673-3680

OFFICE OF SUPPORT SERVICES

545 East Main Street - Canton, PA 17724
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www.canton.k12.pa.us

CANTON AREA ELEMENTARY SCHOOL

545 East Main Street, Canton, PA 17724
Ph: (570) 673-5196 Fax: (570) 673-7929

CANTON JR. SR. HIGH SCHOOL

509 East Main Street, Canton, PA 17724
Ph: (570) 673-5134 Fax: (570) 673-5566

Dear Parent/Guardian of a Student Athlete,

Sports Physicals will be offered to all Canton Jr and Sr. high school students on **Monday, June 10, 2024** based on the times listed below. The physical will consist of vital signs, vision test, height and weight done by the school nurse, flexibility screening with the athletic trainer, and physical exam by the school physician or nurse practitioner. **The cost is \$20 per student** which is due on the day of the physical in the form of cash/check only. **Please make checks payable to: Canton Area School District.** Physical forms can be picked up from the CHS main office and are also can be printed at <https://www.canton.k12.pa.us/wp-content/uploads/2021/06/21-22-Sports-Physical-Info-Packet.pdf>.

Schedule:

8:30 AM-11:30 PM-FOOTBALL/VOLLEYBALL/CROSS COUNTRY/SOCCER

1:00 PM-3:00 PM-WRESTLING/BASKETBALL/SOFTBALL/BASEBALL/CHEER//TRACK

Please contact our Nurse, Mrs. Reed at 570-673-5196 with any questions.

Robert Rockwell

Cindy Reed, RN, BSN, CSN

Athletic Director

School Nurse



**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 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 5: HEALTH HISTORY

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

<p>1. Has a doctor ever denied or restricted your participation in sport(s) for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you have an ongoing medical condition (like asthma or diabetes)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Has a doctor ever told you that you have (check all that apply):</p> <p><input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection</p> <p>10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Does anyone in your family have a heart problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Does anyone in your family have Marfan Syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever spent the night in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; padding: 5px;"> <p>17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, circle affected area below:</p> <p>18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </div> <table border="0" style="width: 100%; font-size: small;"> <tr> <td style="width: 10%;">Head</td> <td style="width: 10%;">Neck</td> <td style="width: 10%;">Shoulder</td> <td style="width: 10%;">Upper arm</td> <td style="width: 10%;">Elbow</td> <td style="width: 10%;">Forearm</td> <td style="width: 10%;">Hand/Fingers</td> <td style="width: 10%;">Chest</td> </tr> <tr> <td>Upper back</td> <td>Lower back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/shin</td> <td>Ankle</td> <td>Foot/Toes</td> </tr> </table> <p>20. Have you ever had a stress fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Do you regularly use a brace or assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/Fingers	Chest	Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/Toes	<p>23. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Is there anyone in your family who has asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Have you ever had a herpes skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; padding: 5px;"> <p>CONCUSSION OR TRAUMATIC BRAIN INJURY</p> <p>31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Do you experience dizziness and/or headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </div> <p>34. Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Are you unhappy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>MENSTRUAL QUESTIONS- IF APPLICABLE</p> <p>47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. How old were you when you had your first menstrual period? _____</p> <p>49. How many periods have you had in the last 12 months? _____</p> <p>50. When was your last menstrual period? _____</p>
Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/Fingers	Chest										
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/Toes										

#s	Explain "Yes" answers here:

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

Student's Signature _____ Date ____/____/____

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

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

SECTION 7: RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal, or the Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY.

If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the herein named student shall submit a completed Section 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

SUPPLEMENTAL HEALTH HISTORY

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

Date of Student's Birth: ____/____/____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Winter Sport(s): _____ Spring Sport(s): _____

CHANGES TO PERSONAL INFORMATION (In the spaces below, identify any changes to the Personal Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Current Home Address _____

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

CHANGES TO EMERGENCY INFORMATION (In the spaces below, identify any changes to the Emergency Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Parent's/Guardian's Name _____ Relationship _____

Parent/Guardian E-mail Address: _____

Address _____ Emergency Contact Telephone # () _____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Telephone # () _____

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

Address _____ Telephone # () _____

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

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

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Since completion of the CIPPE, have you sustained a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? | <input type="checkbox"/> | <input type="checkbox"/> | 3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? | <input type="checkbox"/> | <input type="checkbox"/> | 4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 6. Do you have any concerns that you would like to discuss with a physician? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

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

Student's Signature _____ Date ____/____/____

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

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

PIAA[®]

Promote, Protect and Conserve...



Emergency Card for Athletes

- Emergency card/authorization for each athlete must accompany the athlete at all times.
- The card for each athlete should be carried in the first-aid kit for each sport.
- The card for each athlete should be readily accessible to the Coach, athletic trainer, or emergency personnel.
- Prior to the start of each sport, the card for each athlete should be reviewed by the Coach/trainer/athletic director or any other medical personnel for completeness.
- Include emergency phone numbers or significant medical history.

Please complete the information below prior to participation in each sports' season:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Blood Type: _____

In case of accident or emergency, please contact:

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 # () _____

Pre-Existing Circulatory/Pulmonary Conditions: _____

Diabetes: _____

Inhalers: _____

Allergies or Allergic Reactions: _____

Medications Being Used: _____

Date of Tetanus Immunization: _____

Have you ever had a concussion (i.e. bell rung, ding, head rush) or head injury? _____ Yes _____ No

Other Pertinent Information: _____

Permission to Treat: _____ Parent's/Guardian's Signature

Section 9: CIPPE MINIMUM WRESTLING WEIGHT

INSTRUCTIONS

Pursuant to the Weight Control Program adopted by PIAA, prior to the participation by any student in interscholastic wrestling, the Minimum Wrestling Weight (MWW) at which the student may wrestle during the season must be (1) certified to by an Authorized Medical Examiner (AME) and (2) established NO EARLIER THAN six weeks prior to the first Regular Season Contest day of the wrestling season and NO LATER THAN the Monday preceding the first Regular Season Contest day of the wrestling season (See NOTE 1). This certification shall be provided to and maintained by the student's Principal, or the Principal's designee.

In certifying to the MWW, the AME shall first make a determination of the student's Urine Specific Gravity/Body Weight and Percentage of Body Fat, or shall be given that information from a person authorized to make such an assessment ("the Assessor"). This determination shall be made consistent with National Federation of State High School Associations (NFHS) Wrestling Rule 1, Competition, Section 3, Weight-Control Program, which requires, in relevant part, hydration testing with a specific gravity not greater than 1.025, and an immediately following body fat assessment, as determined by the National Wrestling Coaches Association (NWCA) Optimal Performance Calculator (OPC) (together, the "Initial Assessment").

Where the Initial Assessment establishes a percentage of body fat below 7% for a male or 12% for a female, the student must obtain an AME's consent to participate.

For all wrestlers, the MWW must be certified to by an AME.

Student's Name _____ Age _____ Grade _____
Enrolled in _____ School _____

INITIAL ASSESSMENT

I hereby certify that I have conducted an Initial Assessment of the herein named student consistent with the NWCA OPC, and have determined as follows:

Urine Specific Gravity/Body Weight _____ / _____ Percentage of Body Fat _____ MWW _____

Assessor's Name (print/type) _____ Assessor's I.D. # _____

Assessor's Signature _____ Date ____/____/____

CERTIFICATION

Consistent with the instructions set forth above and the Initial Assessment, I have determined that the herein named student is certified to wrestle at the MWW of _____ during the 20____ - 20____ wrestling season.

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

Address _____ Phone () _____

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

For an appeal of the Initial Assessment, see NOTE 2.

NOTES:

1. For senior high school wrestlers coming out for the Team AFTER the Monday preceding the first Regular Season Contest day of the wrestling season the OPC will remain open until January 15th and for junior high/middle school wrestlers coming out for the Team AFTER the Monday preceding the first Regular Season Contest day of the wrestling season the OPC will remain open all season.
2. Any athlete who disagrees with the Initial Assessment may appeal the assessment results one time by having a second assessment, which shall be performed prior to the athlete's first Regular Season wrestling Contest and shall be consistent with the athlete's weight loss (descent) plan. Pursuant to the foregoing, results obtained at the second assessment shall supersede the Initial Assessment; therefore, no further appeal by any party shall be permitted. The second assessment shall utilize either Air Displacement Plethysmography (Bod Pod) or Hydrostatic Weighing testing to determine body fat percentage. The urine specific gravity testing shall be conducted and the athlete must obtain a result of less than or equal to 1.025 in order for the second assessment to proceed. All costs incurred in the second assessment shall be the responsibility of those appealing the Initial Assessment.

Print Athlete's Name_____
Print Athlete's Sport

As part of a contractual agreement with UPMC Sports Medicine, certified athletic trainers may aide in the prevention, recognition, evaluation, and treatment of athletic injuries. **Please note that the forms below have no relationship to your health insurance plan and in no way, influence your choice of medical care.** UPMC must have these forms completed to comply with privacy and standard consent to treat laws.

(1) UPMC Authorization for Release of Protected Health Information

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

**24-25 CANTON HIGH SCHOOL
ATHLETIC, EXTRA & CO-CURRICULAR
CODE OF CONDUCT**



UPDATED: 4/2024

Mission: We, in the Canton Area School District, believe that a healthy mind and healthy body complement one another. We also believe that learning is not to be limited to the classroom and that participation, athletics and competition, in their proper place and perspective, are other components of the learning process. Therefore, we believe that interscholastic athletics and co-curricular activities should be incorporated into our total educational offerings as integral parts

General Objective: Games and events should have as their chief purposes, friendly rivalries, creation of new friendships, playing skills, good sportsmanship, and improved community relations.

Specific Objectives

Interscholastic Athletics and Co-Curricular Activities at Canton High School

- Provide opportunities to develop skill and to experience the satisfaction of performing effectively in emotionally charged situations.
- Contribute to the development of a health and fitness attitude that will provide a carry-over interest, which will function during leisure time.
- Contribute to the development of a wholesome appreciation for a well-developed and properly conditioned body.
- Contribute to the development of desirable social and citizenship qualities such as responsibility, respect for authority, leadership and fellowship abilities, respect for the rights and properties of others, harmonious and cooperative group action and respect for individual differences.
- Contribute to the satisfaction of certain psychological needs such as: self-understanding, self-expression, recognition and approval.
- Contribute to the development of desirable character traits including persistence, determination, unselfishness, will-to-win, alertness, maximum effort, resourcefulness and tenacity.
- Promote the development of the self-esteem and self-realization of each participant.

Objectives for School and Student body

- Interscholastic athletics and co-curricular activities should occupy a position in the curriculum comparable to that of other subjects or activities.
- Interscholastic athletics and co-curricular activities should be educational.
- Interscholastic athletics and co-curricular activities should be a means of promoting fine school morals.
- All visiting schools should be treated as guests.
- Interscholastic athletic programs and co-curricular activities should be broad rather than narrow in scope.
- Sportsmanship, fair play, and good school citizenship should be objectives of all participants.

Code of Conduct for Participants in Interscholastic Athletics & Co-Curricular Activities

- Appreciate that coaches, advisors, sponsors, and administrators have the best interests of the participants in mind as they plan and conduct their programs.
- Obey the specific training and practice rules of the coach, advisor, or sponsor.

- Be present at practice sessions, rehearsals, games, and scheduled events unless excused by the coach, advisor, or sponsor.
- Practice healthful habits of cleanliness and personal hygiene in all their daily activities.
- Appreciate the importance of proper rest, diet, and exercise.
- Understand that alcohol, tobacco, and illegal/illicit drugs are harmful to the body and mind, and hinder maximum effort and performance.
- Participants should appear neat and well groomed at all times.
- Participants should not use profanity or other inappropriate language/gestures
- Directly represent the coaches, advisors, sponsors, school, community, and should conduct themselves properly at all times. Student/student athletic conduct reflects on the school's reputation.
- Realize that officials do not lose a contest but are there for the purposes of ensuring that both teams/individuals receive a fair deal. For this, they deserve and will receive our courteous respect.
- Do not employ illegal tactics to gain an undeserved advantage.
- Have a good attendance record and will not skip class(es) or be truant from school.
- Care for all equipment as though it were their own personal property. Any loss of or damage to issued equipment (other than normal use/wear) is the participant's responsibility. Students will be held financially responsible for all replacement costs.
- Show sportsmanship at all times and express the importance of teamwork over personal recognition.
- Comply with the standards of the CHS Student Code of Conduct

Sanctions from the Code of Conduct

- Minor Infractions- First infractions of a minor nature, as well as, continued minor infractions should be punishable by the coach/director in a fair but stern manner and commensurate with the seriousness of the infraction. Suggested punishments for minor infractions include, but are not limited to, warnings, conferences, and /or review of the code, loss of assigned responsibilities, probationary status or ineligibility for one or more contests.
- Major Infractions-Infractions of the student code of conduct are considered major and should be reported to the Athletic Director immediately. These infractions include acts of violence, weapons, terroristic threats, controlled substances, alcohol, tobacco and vaping products. Major infractions should be punishable by the administration in a fair but stern manner and commensurate with the seriousness of the infraction according to the information provided below.
 - **School Attendance**
A student must be in good standing (academically eligible) in the school to participate in interscholastic athletics or co-curricular activities. Academic eligibility as defined by the PIAA and the CHS "Pass to Play" program. The Pennsylvania Interscholastic Athletic Association and the CHS "Pass to Play" dictates the ineligibility of any student who does not comply with the established regulations. Students must be present in school prior to 9:00am in order to be ineligible to participate in an extracurricular activity after school. Students arriving

after 9:00am will be eligible only if the absence is accompanied by a medical note or prior approval from the Principal or Athletic Director.

- **Use, Possession or Sale of Tobacco/Vapor Products (222)**
 - 1st Violation during the current school year
 - Suspension from participation for **5** school days and **1** competition
 - Successful completion of a school or community based Tobacco education program.
 - Report to Office of Safe Schools (PDE)
 - 2nd Violation during the current school year
 - Suspension from participation from the activity for the remainder of season or activity duration
 - Successful completion of a school or community based Tobacco education program.
 - Referral to Local Law Enforcement Agency (District Magistrate)
 - Report to Office of Safe Schools (PDE)
 - 3rd Violation during the current school year
 - Suspension from participation in all extra curricular activities for one calendar year
 - Successful completion of a school or community based Tobacco education program.
 - Referral to Local Law Enforcement Agency (District Magistrate)
 - Report to Office of Safe Schools (PDE)
- **Use, Possession or Sale of Illegal drugs, controlled substances or alcoholic beverages (227)** NOTE: Attendance by a student at an event where alcoholic beverages, illegal drugs or controlled substances are provided for or consumed by persons under the age of 21 in the absence or the presence and approval of the parents or guardians of those underage persons is a violation of training rules and is subject to the disciplinary code below.
 - 1st Violation during the current school year
 - Immediate Suspension from all extra curricular activities for 45 school days
 - Referral to law enforcement
 - Successful completion of Drug & Alcohol Assessment by a licensed facility
 - Report to Office of Safe Schools (PDE)
 - 2nd Violation during the current school year
 - Immediate Suspension from all extra curricular activities for one calendar year
 - Referral to law enforcement
 - Successful completion of Drug & Alcohol Assessment by a licensed facility
 - Report to Office of Safe Schools (PDE)

- **Violence Resulting In Serious Bodily Injury (218.2, 252)**
 - 1st Violation during the current school year
 - Immediate Suspension from all extra curricular activities for 45 school days
 - Referral to law enforcement
 - Completion of a mental health evaluation by the school or other licensed facility
 - Report to Office of Safe Schools (PDE)
 - 2nd Violation during the current school year
 - Immediate Suspension from all extra curricular activities for one calendar year
 - Referral to law enforcement
 - Completion of a mental health evaluation by the school or other licensed facility
 - Report to Office of Safe Schools (PDE)
- **Possession of Weapon(s) (218.1)**
 - 1st Violation during the current school year
 - Immediate Suspension from all extra curricular activities for **up to** 45 school days
 - Referral to law enforcement
 - Completion of a mental health evaluation by the school or other licensed facility **may be required**
 - Report to Office of Safe Schools (PDE)
 - 2nd Violation during the current school year
 - Immediate Suspension from all extra curricular activities for 45 school days
 - Referral to law enforcement
 - Completion of a mental health evaluation by the school or other licensed facility
 - Report to Office of Safe Schools (PDE)
- **Use, Possession or Sale of Anabolic Steroids (227)**
 - 1st Violation during the current school year
 - Immediate Suspension from all extra curricular activities for the remainder of the season
 - Report to Office of Safe Schools (PDE)
 - Medical determination by a licensed provider confirming no residual evidence of the steroid exists.
 - 2nd Violation during the current school year
 - Immediate Suspension from all extra curricular activities for the remainder of the season and the following season
 - Report to Office of Safe Schools (PDE)
 - Medical determination by a licensed provider confirming no residual evidence of the steroid exists.

- 3rd Violation, permanent suspension from school athletics.
 - Immediate and permanent suspension from school athletics for the remainder of high school career
 - Report to Office of Safe Schools (PDE)
- **Court Proceedings, Probation, Law Enforcement Involvement**
 - A student will be declared ineligible to participate in any interscholastic, athletic, and/or co-curricular activity in which he/she represents the school in a public appearance if placed on probation for the duration of the assigned time period.

Apply the sanctions to the Code

A STUDENT'S FAILURE TO ADHERE TO TRAINING RULES AND STANDARDS (CANTON ATHLETICS/CO-CURRICULAR CODE OF CONDUCT AND STUDENT HANDBOOK POLICIES) DESCRIBED HEREIN MAY AMOUNT TO SELF-DISQUALIFICATION FROM INTERSCHOLASTIC ATHLETICS AND/OR CO-CURRICULAR ACTIVITIES. The head coach, coaching staff, adviser, sponsor, chaperones (when authorized) or school administration of necessity, have the right to exercise judgment in matters of enforcing the rules and must apply penalties impartially. The principal will take action on major infractions and matters requiring administrative attention. The athletic director will investigate, review options for sanctions and report, with recommendations to the principal.

Student and Parent Acknowledgement

If I am accepted as a member of a sport or activity(ies) group, I will obey all rules and regulations of the sport/activity(ies) as well as the Canton Athletic/Co-Curricular Code of Conduct. Additionally, I will obey all regulations contained in the Canton Jr./Sr. High School Student Handbook. I realize that failure to meet these requirements will amount to my self-disqualification and dismissal from the sport/activity(ies). As the student, I have read and understand the requirements, rules, and consequences of this code. As a Parent/Legal Guardian, your signature acknowledges the school's scope of authority over our child.

Student Name

Student Signature

Date

Parent/Guardian Name

Parent/Guardian Signature

Date