

**CEDAR CLIFF HIGH SCHOOL**

John Kosydar – Athletic Director

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1301 Carlisle Road  
Camp Hill, PA 17011-6199Phone 717-737-8654  
Fax 717-737-0874**2020-2021**

Dear Parent or Guardian:

Your child has expressed an interest in participating in an athletic program at Cedar Cliff High School. These are programs for those students desiring a level of competition beyond that provided in the physical education program. An activity fee is required for participation in athletics and student activities. Beginning with our 2020-2021 school year, we will begin utilizing the online [K12PaymentCenter](#) to collect our athletic/student activity fees. This payment system is also utilized for the school lunch program. All Activity Fees have been adjusted to absorb the additional convenience fees that may be charged by paying online. Please click on the link provided for updated fees. [Activity Fee Forms](#). The fee will be assessed per sport and activity. There is a student cap of \$190.00 and a family cap of \$380.00. Fees **must be paid** and submitted within two (2) weeks of the start of practice and no later than the first (1<sup>st</sup>) competition date.

**Prefer to Pay Online**

- Families with a [K12PaymentCenter](#) account will see the activity fee for their child listed. Simply add the fee to your cart to process.
- Families who **do not have a** [K12PaymentCenter](#) account will need to create an account. After logging in, you will see the activity fee for your child. Simply add the fee to your cart to process.
  - Please note that a valid email and Student Number are needed to create a new account. *Student numbers can be found in [PowerSchool](#) online (the number is not available in the mobile app). The student's ten-digit identification number appears immediately after the student's middle name across the top of the screen.*

**Prefer to Pay by Check**

- Parents, who prefer **not to utilize** the K12PaymentCenter, should submit a check made payable to West Shore School District as follows:

West Shore School District  
Attention: Athletic/Student Activity Fee  
507 Fishing Creek Road  
PO Box 803  
New Cumberland, PA 17070

**Waiver Option**

- Families who wish to apply for an Activity Fee Waiver should contact their High School Athletic Department. Activity Fee Waiver Forms can be found at this link: [Activity Fee Waiver Form](#)  
The High School Athletic Director will process activity Fee Waivers.

If you have any questions regarding the assigned payment, please email Kim McDermitt at [kmcdermitt@wssd.k12.pa.us](mailto:kmcdermitt@wssd.k12.pa.us)

\*[K12PaymentCenter](#) uses a variable convenience fee based on the payment amount. For payments up to \$95, the convenience fee will remain at \$1.95. For payments over \$95, the convenience fee will be 3.99%. Additionally, you have the option of using electronic checks, which will offer a convenience fee of \$0.95 regardless of the amount paid. *Please note, West Shore School District does not receive any of the convenience fees.*

The winter sports season begins Friday, November 20, 2020. Individual coaches will let their players know at what time and place to pick up any required equipment. The individual coaches will let the athletes know where practice is and when it starts.

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

### Winter Sports Offered at Cedar Cliff High School

#### Winter Sports:

Boys Basketball	Head Coach	Tigh Savercool	(Grades 9-12)	<a href="mailto:tsave31@gmail.com">tsave31@gmail.com</a>
Girls Basketball	Head Coach	Scott Weyant	(Grades 9-12)	<a href="mailto:sweyant@wssd.k12.pa.us">sweyant@wssd.k12.pa.us</a>
Wrestling	Head Coach	Richard Tamanosky II	(Grades 9-12)	<a href="mailto:ricktam@comcast.net">ricktam@comcast.net</a>
Boys and Girls Swimming	Head Coach	Joseph Chubb	(Grades 9-12)	<a href="mailto:coachchubb@gmail.com">coachchubb@gmail.com</a>
WSSD Diving	Head Coach	Rebecca Rundall	(Grades 9-12)	<a href="mailto:RRundall@wssd.k12.pa.us">RRundall@wssd.k12.pa.us</a>

#### Junior High/Freshman Winter Sports:

Boys Basketball (9 <sup>th</sup> )	Head Coach	TBD		
Girls Basketball (9 <sup>th</sup> )	Head Coach	Anita Uibel		<a href="mailto:auibel@verizon.net">auibel@verizon.net</a>
Boys Basketball (Junior High)	Head Coach	Chris Houser	(Grades 7-8)	<a href="mailto:chouser259@hotmail.com">chouser259@hotmail.com</a>
Girls Basketball (Junior High)	Head Coach	Chris Reilly	(Grades 7-8)	<a href="mailto:reillyc4@hotmail.com">reillyc4@hotmail.com</a>
Wrestling (9 <sup>th</sup> )	Head Coach	Robert Lewis	(Grades 7-9)	<a href="mailto:lewisrw76@gmail.com">lewisrw76@gmail.com</a>

#### Athletic Trainer:

Athletic Trainer	Head Trainer	Marina Rosario		<a href="mailto:mrosario@wssd.k12.pa.us">mrosario@wssd.k12.pa.us</a>
Athletic Trainer	Asst. Trainer (Trainer B)	Kristin Lyons		<a href="mailto:klyons@wssd.k12.pa.us">klyons@wssd.k12.pa.us</a>

**\*\*\*\*All physical paperwork must be turned into the athletic trainer no later than Friday, November 13, 2020**

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



Submit checklist with completed packet materials. Please print information.

Student Name: \_\_\_\_\_

School: \_\_\_\_\_

Sport: \_\_\_\_\_

Follow checklist per criteria listed below.

### **Re-Certification Packet**

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

- Complete PIAA Re-Certification Packet
  - Section 7 – Re-Certification by Parent/Guardian (Supplemental Health History Questions)
    - If answer **YES** to a/any Supplemental Health History Question(s) on Section 7, then Section 8 is also required.
  - Section 8 – Re-Certification by **Licensed Physician of Medicine or Osteopathic Medicine**
- Medical Release/Insurance Form
- Submit Completed Packet to High School Athletic Trainer**
- Submit Activity Fee Payment  
(due by first competition date for your activity).
- FOR HOMESCHOOL, CYBER SCHOOL AND CHARTER SCHOOL STUDENTS ONLY**  
Submit Intent to Participate Form  
Available on the District website [www.wssd.k12.pa.us](http://www.wssd.k12.pa.us) on the Cedar Cliff and Red Land High School Athletics Department Web-pages

## SECTION 7: RE-CERTIFICATION BY PARENT/GUARDIAN

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

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

### SUPPLEMENTAL HEALTH HISTORY

Student's Name \_\_\_\_\_ Male/Female (circle one)

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

Winter Sport(s): \_\_\_\_\_ Spring Sport(s): \_\_\_\_\_

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

Current Home Address \_\_\_\_\_

Current Home Telephone # ( ) \_\_\_\_\_ Parent/Guardian Current Cellular Phone # ( ) \_\_\_\_\_

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

Parent's/Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Emergency Contact Telephone # ( ) \_\_\_\_\_

Secondary Emergency Contact Person's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Emergency Contact Telephone # ( ) \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

Address \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_

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

Address \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_

**SUPPLEMENTAL HEALTH HISTORY:**

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

- |  | Yes                      | No                       |  | Yes                      | No                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Since completion of the CIPPE, have you sustained an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? | <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"/> |
| 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"/> | 5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills?  | <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"/> | 6. Do you have any concerns that you would like to discuss with a physician?   | <input type="checkbox"/> | <input type="checkbox"/> |

#s	Explain "Yes" answers here:

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

Student's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section 8: Re-CERTIFICATION BY LICENSED PHYSICIAN OF MEDICINE OR OSTEOPATHIC MEDICINE**

This Form must be completed for any student who, subsequent to completion of Sections 1 through 6 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 8 may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to the Principal, or the Principal's designee, of the student's school, who, pursuant to ARTICLE X, LOCAL MANAGEMENT AND CONTROL, Section 2, Powers and Duties of Principal, subsection C, of the PIAA Constitution, shall "exclude any contestant who has suffered serious illness or injury until that contestant is pronounced physically fit by the school's licensed physician of medicine or osteopathic medicine, or if none is employed, by another licensed physician of medicine or osteopathic medicine."

**NOTE: The physician completing this Form must first review Sections 5 and 6 of the herein named student's previously completed CIPPE Form. Section 7 must also be reviewed if both (1) this Form is being used by the herein named student to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in a subsequent sport season in the same school year AND (2) the herein named student either checked yes or circled any Supplemental Health History questions in Section 7.**

**If the physician completing this Form is clearing the herein named student subsequent to that student sustaining a concussion or traumatic brain injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.**

Student's Name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Enrolled in \_\_\_\_\_ School \_\_\_\_\_

Condition(s) Treated Since Completion of the Herein Named Student's CIPPE Form: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**A. GENERAL CLEARANCE:** Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with no restrictions, except those, if any, set forth in Section 6 of that student's CIPPE Form.

Physician's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ MD or DO (circle one) Date \_\_\_\_\_

**B. LIMITED CLEARANCE:** Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with, in addition to the restrictions, if any, set forth in Section 6 of that student's CIPPE Form, the following limitations/restrictions:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Physician's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ MD or DO (circle one) Date \_\_\_\_\_

## Medical Release/Insurance Form

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

School \_\_\_\_\_ School Year \_\_\_\_\_ Current Grade \_\_\_\_\_

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Student Address \_\_\_\_\_

Parent/Guardian's Name(s) \_\_\_\_\_

Address (if different from student) \_\_\_\_\_

Parent/Guardian's Phone #s 1. ( \_\_\_\_\_ ) \_\_\_\_\_ 3. ( \_\_\_\_\_ ) \_\_\_\_\_

*Please list in order of preference for calls.*

2. ( \_\_\_\_\_ ) \_\_\_\_\_ 4. ( \_\_\_\_\_ ) \_\_\_\_\_

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

Contact Name \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

### Medical Insurance

Name of Company \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Employing Company \_\_\_\_\_

Company Address \_\_\_\_\_

### Medical Record

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

Allergies to Medication \_\_\_\_\_

Other Allergies \_\_\_\_\_

Serious Illnesses \_\_\_\_\_

Current Medication(s) \_\_\_\_\_

Other Health Problems \_\_\_\_\_

Date of Last Tetanus Shot \_\_\_\_\_

### Parental Consent

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

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Student \_\_\_\_\_