



**CATASAUQUA AREA SCHOOL DISTRICT  
ATHLETIC DEPARTMENT**

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**RE-CERTIFICATION FOR  
SPRING SPORTS**

**COMPLETE THE FAMILY ID REGISTRATION FOR SPRING SPORTS**

Registration for FamilyID is now required for each season. The online registration has been revised and is now easier to complete.

**SECTION #2: CERTIFICATION OF PARENT/GUARDIAN**

**SIX signatures are required by the parent/guardian.** A signature in Section A by the sport your son/daughter is participating in during the spring sports season and signatures in Sections B, C, D, E and F.

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

Please make any changes to personal and medical information in the top section.

**The six yes/no questions at the bottom are required. The student's signature and parent/guardian's signatures are also required at the bottom of the form.**

**SECTION #8: CERTIFICATION BY LICENSED PHYSICIAN OF MEDICINE OR  
OSTEOPATHIC MEDICINE (READ CAREFULLY)**

This section is required only if you answered **YES** to any of the six questions in SECTION #7. **(THIS SECTION IS NOT ATTACHED. IF NEEDED, THE FORM CAN BE FOUND UNDER ATHLETIC DEPARTMENT FORMS ON WWW.CATTYSD.ORG.)**

**ALL SIGNED PAPERWORK MUST BE COMPLETED AND RETURNED  
TO THE CHS ATHLETIC OFFICE OR TO MR. SONNTAG OR MR.  
SNYDER AT CMS BY TUESDAY, FEBRUARY 20<sup>TH</sup>.**

**THE FIRST OFFICIAL DAY OF SPRING SPORTS IS MONDAY, MARCH 4<sup>TH</sup>.**

**PLEASE CONTACT THE CHS ATHLETIC OFFICE WITH ANY QUESTIONS.**

October 25, 2022



Dear Parents/Guardians,

The Catasaquua High School Athletic Department offers the convenience of online registration through FamilyID (<https://students.arbitersports.com/organizations/catasauqua-high-school>)

FamilyID is a secure registration platform that provides you with an easy, user-friendly way to register for our programs, and helps us to be more administratively and environmentally responsible. When you register through FamilyID, the system keeps track of your information in your FamilyID profile. You enter your information only once for each family member for multiple uses and multiple programs.

#### **INFORMATION NEEDED TO REGISTER:**

It will be helpful to have the following information handy to allow for accurate completion of your online registration.

- Doctor Information, Health Insurance Information, and Phone Numbers

#### **REGISTRATION PROCESS:**

A parent or guardian should register by clicking on this link:

<https://students.arbitersports.com/organizations/catasauqua-high-school>

#### **Follow these steps:**

1. Click on Catasaquua High School Athletics Registration (highlighted in blue).
2. Next click on the green **Register Now** button and scroll, if necessary, to the **Create Account/Log In** green buttons. If this is your first time using FamilyID, click **Create Account**. Click **Log In**, if you already have a FamilyID account.
3. **Create** your secure FamilyID account by entering the account owner First and Last names (parent/guardian), E-mail address and password. Select **I Agree** to the FamilyID Terms of Service. Click **Create Account**.
4. You will receive an email with a link to activate your new account. (If you do not see the email, check your E-mail filters (spam, junk, etc.)
5. Click on the link in your activation E-mail, which will log you in to FamilyID.com
6. Once in the registration form, complete the information requested. All fields with a red\* are required to have an answer.
7. Click the **Save & Continue** button when your form is complete.
8. Review your registration summary.
9. Click the green **Submit** button. After selecting Submit, the registration will be complete. You will receive a completion email from FamilyID confirming your registration.
10. No payment is required for online registration.
11. At any time, you may log in to update your information and to check your registration(s).
12. To view a completed registration, select the Registration tab on the blue bar.

#### **SUPPORT:**

If you need assistance with registration, contact FamilyID at [support@familyid.com](mailto:support@familyid.com) or 888-800-5583 extension 1. Support is available 7 days a week and messages will be returned promptly.

**PLEASE CONTACT THE CHS ATHLETIC OFFICE AT 610-697-0111  
EXTENSION 2 WITH ANY ADDITIONAL QUESTIONS OR CONCERNS.**

## SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

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

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

Fall Sports	Signature of Parent or Guardian
Cross Country	
Field Hockey	
Football	
Golf	
Soccer	
Girls' Tennis	
Girls' Volleyball	
Water Polo	
Other	

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Competitive Spirit Squad	
Girls' Gymnastics	
Rifle	
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	
Girls' Lacrosse	
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
Boys' Volleyball	
Other	

**B. Understanding of eligibility rules:** I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at [www.piaa.org](http://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 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.

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? ☐ Yes ☐ No

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

2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? ☐ Yes ☐ No

	Yes	No
3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?	<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"/>

#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 \_\_\_\_/\_\_\_\_/\_\_\_\_