

## **PARENTAL PERMISSION FORM**

I hereby grant \_\_\_\_\_ High School permission to allow an assessment to be performed by a CIF Certified Assessor provided for my son/daughter for the purpose of determining body fat under the CIF Wrestling Weight Certification Program. I understand that the CIF requires this assessment to be completed in order for my son/daughter to be eligible to compete in wrestling in any CIF competition.

I hereby agree to release, discharge and forever hold harmless the CIF, the school and CIF Certified Assessors from any and all claims, I am free to deny any consent for my son/daughter both now and at any point during the testing.

I acknowledge that I have read this form in its entirety or it has been read to me, and I understand the testing procedure in which my son/daughter may be engaged. I consent and give permission for my son/daughter to participate in this assessment.

DATE \_\_\_\_\_

NAME OF STUDENT-ATHLETE \_\_\_\_\_

STUDENT SIGNATURE \_\_\_\_\_

NAME OF PARENT/GUARDIAN \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

PLEASE RETURN NO LATER THAN \_\_\_\_\_, 20\_\_

TO: Head Wrestling Coach

# INDIVIDUAL PROFILE DATA FORM

## WRESTLER'S IDENTIFICATION INFORMATION

Please complete the requested information immediately below, prior to arriving at your weight certification assessment:

**\*\*Coaches:** Please make a copy of this form for each of your wrestlers. This form must be given to your Certified Assessor to complete the assessment for each wrestler. The Certified Assessor will retain this form.

Parental Permission Form signed: **yes** \_\_\_\_\_ **no** \_\_\_\_\_ (if no, do not assess wrestler)

Please complete (PRINT) the first three lines.

Name: \_\_\_\_\_ Grade: 9 10 11 12  
Last, First MI

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

Gender: M / F Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## DATA COLLECTION INFORMATION

To be completed ONLY by the CIF Assessor or designated Assistant

(Date of) Initial Assessment \_\_\_\_\_

(Date of) Appeal of Initial Assessment \_\_\_\_\_

(Circle One) **BODYMETRIX**

### 1. HEIGHT MEASUREMENT:

Height: (Actual) \_\_\_\_\_ (nearest 1/2") \_\_\_\_\_

### 2. BODY COMPOSITION TESTING (BODYMETRIX)

Weight: \_\_\_\_\_ lbs BODY FAT % \_\_\_\_\_

CIF Assessor's signature \_\_\_\_\_ Alpha Date \_\_\_\_\_

CIF Assessor's Name \_\_\_\_\_

## **APPEAL FORM #2**

### **AIR DISPLACEMENT BODY COMPOSITION REPORT FORM**

#### **STEP 1**

A wrestler may choose, at his/her own cost, to appeal the body composition test. The appeal may only utilize air displacement measurements to determine body fat percentage. Results obtained at this step are automatically accepted; the athlete, family, school, or coach may not appeal further. The Section Office must be notified that the wrestler had chosen to appeal the body composition test.

A. Student to be weighed: \_\_\_\_\_ Grade: \_\_\_\_\_

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

B. AIR DISPLACEMENT WEIGHING FACILITY: \_\_\_\_\_

Technician CONDUCTING THE WEIGHING: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

C. We understand that the results of the air displacement weighing will replace all previous results, cannot be appealed, cannot be modified by the Physician's Clearance form, or any other action, and will remain the reference for this student during this school year.

Parent Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_

D. Results of the air displacement weighing measurement

Height \_\_\_\_\_

Weight \_\_\_\_\_

Age \_\_\_\_\_

% Body fat: \_\_\_\_\_

\_\_\_\_\_  
Signature of Head Coach

\_\_\_\_\_  
Print Head Coach

\_\_\_\_\_  
Signature of Person Conducting Test

\_\_\_\_\_  
Title

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Phone Number

The Head Coach should submit this completed form to the athletes Section office.

# PHYSICAL CLEARANCE FOR WRESTLER BODY FAT ALLOWANCE

This form should be completed and submitted to your Section Office, prior to the athlete competing.

## TO THE PHYSICIAN:

The CALIFORNIA INTERSCHOLASTIC FEDERATION (CIF) has instituted the California Weight Monitoring Program to encourage healthy weight management by interscholastic wrestlers. As part of this program, a minimum weight is established for each wrestler prior to their competitive season. Each wrestler's body fat and lean body mass is measured by a CIF Certified Assessor. The standard error for this method is  $\pm 4\%$  for higher weights. A minimum weight is then calculated as 7% body fat for males and 12% for females.

Your patient was assessed during the pre-season as less than 7% body fat (or 12% for females). The athlete is requesting that he or she be allowed to wrestle at his or her present weight – (alpha weight). Because this weight is less than 7% (for males) and 12% (for females) body fat, CIF guidelines require permission from the athlete's personal physician. Most adolescents require 5-7% body fat (males) or 10-12% body fat (females) to achieve optimal growth and development. However, there are some adolescents who are naturally lean and develop normally at a lower percent body fat.

Please evaluate your patient for normal growth and development, paying particular attention to weight fluctuations and his or her growth curve. Based on the patient's history and your examination, determine if his/her present weight is compatible with normal growth, development, and good health.

Thank you,

Wrestler's name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

## FOR ASSESSOR TO COMPLETE DATA REVIEW

Alpha Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_ Alpha Weight: \_\_\_\_\_ lbs. Body fat: \_\_\_\_\_ %

Weight class that immediately exceeds the Alpha Weight: \_\_\_\_\_ lbs.

Assessor Initials \_\_\_\_\_

I have examined the above named student-athlete and believe that based on the patient's history, and this examination, that his/her present weight is compatible with normal growth, development, and good health. I therefore approve of this student-athlete's participation at the weight class at or above the Alpha Weight listed above.

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

As the parent or guardian of the above named student-athlete I support our doctor's decision regarding our son's/daughter's participation at the weight class at or above the Alpha Weight listed above.

PARENT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

As the coach for this athlete I support the doctor's and parent's decision regarding their patient's/son/daughter's participation at the weight class at or above the Alpha Weight listed above.

COACH'S SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

As the principal of the above named student-athlete's high school I affirm that the process of Physician Clearance has been completed properly.

PRINCIPAL SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_