



(SCHOOL NAME/ LOGO/ ADDRESS  
HERE)

### PARENTAL PERMISSION FORM

I hereby grant \_\_\_\_\_ high school permission to allow a hydration assessment to be performed by a CIF Certified Assessor on a urine sample provided by my son/daughter for the purpose of determining if the appropriate hydration level has been met 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 for the 2008-2009 school year.

By my signature below I understand that my son/daughter agree to the following:

- Ø A 20-30ml (1-2 oz) urine sample will be provided by my /son/daughter in a restroom facility for the sole purpose of being analyzed for the hydration (specific gravity) to be measured and recorded by a CIF Assessor.
- Ø My son/daughter's sample will remain in their possession and under their direct supervision throughout the assessment. They will dispose of their own sample upon completion of the assessment.

I further understand the following:

- Ø The location where the sample is being provided will be supervised by school personnel to ensure that the wrestler has provided a sample of his/her own urine without any contamination (females will supervise locations used by female wrestlers; males will supervise locations used by male wrestlers).
- Ø Every reasonable measure will be taken to ensure privacy for the wrestler when he/she is submitting a urine sample.
- Ø Other than for the hydration testing, the urine sample provided will not be used for any other type of analysis or testing.
- Ø The National Institute of Health recommends that individuals who have implanted defibrillators should not participate in this test. There is no scientific evidence that bioelectrical impedance is safe on the fetus during pregnancy.

I hereby agree to release, discharge and forever hold harmless the CIF, the school and CIF Certified Assessors from any and all claims, which I might now, or hereby have with respect to the urine testing I am consenting to herein. 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 hydration testing procedure in which my son/daughter will be engaged. I consent and give permission for my son/daughter to participate in this hydration testing.

DATE \_\_\_\_\_

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

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

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

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

PLEASE RETURN NO LATER THAN \_\_\_\_\_, 200\_\_

TO: (INSERT SCHOOL INFORMATION HERE)



Northern Section CIF  
 2241 St. George Lane, Suite 2  
 Chico, CA 95926  
 Phone: 530-343-7285  
 Fax 530-343-5619  
 Web Site: [www.cifns.org](http://www.cifns.org)

California Interscholastic Federation

## INDIVIDUAL PROFILE 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: <b>yes</b> _____ <b>no</b> _____ (if no, do not assess wrestler)			
(Check one) Initial Assessment _____	Retest Failed Hydration _____	Appeal of Initial Assessment _____	Date of Initial Assessment _____
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

### 1. HYDRATION TEST:

Specific Gravity of urine: READING \_\_\_\_\_ PASS \_\_\_\_\_ FAIL \_\_\_\_\_  
 \*(must be 1.025 or LOWER for assessment to continue)

### 2. HEIGHT MEASUREMENT:

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

### 3. BODY COMPOSITION TESTING (Tanita Scale)

Weight: \_\_\_\_\_ lbs Tanita FAT % \_\_\_\_\_

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

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

\*If a wrestler is dehydrated and does not meet the standard (1.025 or lower), any further testing stops. The wrestler cannot be tested again for 24 hours from the time he/she failed the previous test.

Assessors must forward completed Student Profile Forms with Tanita thermal printouts attached to:

(section office)

(street address, city, CA, zip)

**APPEAL FORM**

**AIR DISPLACEMENT BODY COMPOSITION REPORT FORM**

**STEP 1**

A wrestler may choose, at his/her own cost, to appeal the Tanita scale 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 Tanita scale 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 Tanita 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 Person Conducting Test

\_\_\_\_\_  
Title

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

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

Submit this completed form to Northern Section, 2241 St. George Lane, Suite 2, Chico, CA 95926  
(FAX) 530-343-7285  
(Phone) 530-343-5619

Physician Clearance  
For  
**WRESTLER BODY FAT ALLOWANCE**

**This form shall be completed and filed with Northern Section, prior to the athlete competing.  
Fax – 530-343-5619**

**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 through BIA measurements. 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, Northern Section, CIF

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

**DATA REVIEW**

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

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

**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:** \_\_\_\_\_

**High School:** \_\_\_\_\_

Note: This form is the only document accepted as a "Physician Clearance". Mail or fax a copy of this form to [SECTION]. Wrestler may not compete until form has been received and posted on the team's "Alpha Master". Each coach should carry a copy of this Physician's Clearance until the North Coast Section Office updates the Alpha Master List.