

## 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 20-21 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 \_\_\_\_\_

Home Phone # ( ) \_\_\_\_\_ Parent/Guardian Cell Phone # ( ) \_\_\_\_\_ Parent e-mail: \_\_\_\_\_

**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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_