

**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                       |                                                                                                                                                                                        |
| 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"/> |                                                                                                                                                                                        |
| 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"/> |                                                                                                                                                                                        |
| 3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                        |
|                                                                                                                                                                              | Yes                      | No                       |                                                                                                                                                                                        |
|                                                                                                                                                                              |                          |                          | 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 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 \_\_\_\_/\_\_\_\_/\_\_\_\_