

SECTION 5: RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed 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 Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY and make a determination as to whether the student should be re-evaluated and re-certified by an Authorized Medical Examiner pursuant to Section 6.

SUPPLEMENTAL HEALTH HISTORY

Student's Name _____ Age _____ Grade _____

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):

Primary Emergency Contact Person'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. Have you sustained an illness and/or injury related to sport(s) since completion of the CIPPE?	<input type="checkbox"/>	<input type="checkbox"/>	5. Have you experienced dizzy spells, blackouts, and/or unconsciousness?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you sustained an illness and/or injury NOT related to sport(s) since completion of the CIPPE?	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been confined to an institution and/or at home as a result of an illness and/or injury since completion of the CIPPE?	<input type="checkbox"/>	<input type="checkbox"/>	7. Have you experienced any new health problems since completion of the CIPPE?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had surgery since completion of the CIPPE?	<input type="checkbox"/>	<input type="checkbox"/>	8. Are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills since completion of the CIPPE?	<input type="checkbox"/>	<input type="checkbox"/>
			9. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

No(s).	Explain "Yes" answers here:

SUBSEQUENT SPORT(S) TO BE PLAYED: _____ **SEASON:** Fall Winter Spring (circle one)

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 ____/____/____

NOTE: If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the Principal, or Principal's designee, of the herein named student's school shall require the student to complete Section 6 prior to being eligible to participate in sport(s) identified above.