SECTION 5: 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 Contest 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 6, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal or Principal's designee, of the student's school.

Student's Name _____ Male/Female (circle one)

Age_____ Grade _____Sport _____

If your personal or emergency information **HAS NOT** changed since the previous sports season **CHECK** this box ☐ and **move on** to the **Supplemental Health History** Section

If your PERSONAL information HAS changed, please complete this section:

Current Home Address _____

Current Home Telephone# ( )_____ Parent/Guardian Cell Phone# ( )_____

If your EMERGENCY information HAS changed, please complete this section:

Primary Emergency Contact_____ Relationship_____

Address _____Emergency Contact's Phone#_____

Medical Insurance Carrier_____Policy Number_____

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?	☐	☐
2. Since completion of the completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or head injury	☐	☐
3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?	☐	☐
4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	☐	☐
5. Since completion of the CIPPE, are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills?	☐	☐
6. Do you have any concerns that you would like to discuss with a physician?	☐	☐

#'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**____/____/____

Revised: May 20, 2010