SECTION 8: 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 9, 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 # ( )_____

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 9, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.
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 a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine?	❑	❑
An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below		
2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain 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 medicines or pills?	❑	❑
6. Do you have any concerns that you would like to discuss with a physician?	❑	❑

#'s	Explain yes answers; include injury, type of treatment & the name of the medical professional seen by student

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____/____/_____

LAMPETER-STRASBURG SCHOOL DISTRICT

SPORTS EMERGENCY FORM

THIS FORM IS THE EMERGENCY FORM THAT WILL BE KEPT IN THE SPORTS TEAM MEDICAL KIT.
PL EASE PRINT CLEARLY IN INK.

Student Name_____ Date of Birth: _____ Grade_____ Sport _____

PERSONAL INFORMATION:

Street Address_____ City_____ Zip Code_____

Home Telephone_____Parents/Guardians_____

Father's Place of Work_____ Work Phone_____ Cell Phone_____

Mother's Place of Work_____ Work Phone_____ Cell Phone_____

Family Physician_____ Phone_____ Hospital Preference_____

Alternate Person to Be Responsible for Child_____ Phone_____

INSURANCE COVERAGE:

All students participating in interscholastic athletics are supplied with student accident insurance by the school district with the terms of such covered dictated by the policy on file with the school district. The coverage provided is for an accident on the part of a student while participating in an interscholastic sport. The district supplied coverage is secondary to the parent's coverage.

PARENT/GUARDIAN PERMISSION:

I grant permission for my child to have injuries treated by the athletic trainer and team physician and for medical personnel, at their discretion, to release school health record medical information to those individuals deemed necessary by the medical personnel. If a hospital is necessary, I grant permission to have my child transported to the nearest hospital, and I assume responsibility for fees incurred by such an emergency. I understand that the athletic trainer and the team physician have final authority to clear or to disqualify my child for activity following any injury or illness.

The information provided on this form is true and complete to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE_____ **DATE**_____

MEDICAL HISTORY:
Please explain any "YES" answers

	YES	NO	EXPLAIN
Asthma	☐	☐	_____
Diabetes	☐	☐	_____
Heart Problems	☐	☐	_____
Vision Problems	☐	☐	_____
Food/Medication/Insect Allergies	☐	☐	_____
History of Heat Illness	☐	☐	_____
Concussion History (dates, symptoms, length of recovery)	☐	☐	_____
Special Medical Conditions (not otherwise listed)	☐	☐	_____

Date of Most Recent Tetanus Immunization _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____