## 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 |
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**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____/____/_____