

**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 the 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.	Since completion of the CIPPE, have you sustained an illness and/or injury related to sport(s)?	<input type="checkbox"/>	<input type="checkbox"/>	5.	Have you experienced dizzy spells, blackouts, and/or unconsciousness?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Since completion of the CIPPE, have you sustained an illness and/or injury NOT related to sport(s)?	<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.	Since completion of the CIPPE, have you been confined to an institution and/or at home as a result of an illness and/or injury?	<input type="checkbox"/>	<input type="checkbox"/>	7.	Since completion of the CIPPE, have you experienced any new health problems?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Since completion of the CIPPE, have you had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	8.	Since completion of the CIPPE, are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills?	<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 the 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.