SECTION 7: 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 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

	SUPPLI	EMENTAL HEALT	H HISTORY				
Stud	lent's Name				Male/Fe	emale (c	ircle one)
Date of Student's Birth:/ Age of Stude			nt on Last Birthday: Grade for Current Schoo			ol Year:	
Wint	er Sport(s):	Spring	Sport(s):				
	NGES TO PERSONAL INFORMATION (In the space original Section 1: Personal and Emergency Infor		ify any changes t	o the Person	al Informati	on set f	orth in
Curr	ent Home Address						
Curr	ent Home Telephone # ()	Parent/Gua	ardian Current Cell	ular Phone #	()		
	NGES TO EMERGENCY INFORMATION (In the spine original Section 1: Personal and Emergency Inf		ntify any changes	s to the Emer	gency Infor	mation	set forth
Pare	ent's/Guardian's Name			Relation	nship		
Pare	ent/Guardian E-mail Address:						
Addı	ress	Emerg	ency Contact Tele	phone # ()		
Sec	ondary Emergency Contact Person's Name			Relati	onship		
Addı	ress	Emerg	ency Contact Tele	phone # ()		
	ical Insurance Carrier						
Address			Telephone # ()				
Fam	ily Physician's Name				, MD o	r DO (ci	rcle one)
Addı	ress		Telep	hone # ()		
the s Expl Circl 1.	pleted Section 8, Re-Certification by Licensed Physician student's school. ain "Yes" answers at the bottom of this form. le questions you don't know the answers to. Yes 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? dditional note to item #1. if serious illness or serious injury warked "Yes", please provide additional information below Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	3. No 4.	Since completic experienced dizzy unconsciousness' Since completic experienced any e shortness of breat pain? Since completic taking any NEW p pills?	on of the CIPPE as spells, blackor? on of the CIPPE episodes of une th, wheezing, a con of the CIPPE prescription means to concerns the	E, have you uts, and/or E, have you explained and/or chest E, are you dicines or	yes Yes	signee, of No
#'s	Explain yes answers; include injury, type o	f traatment & the	name of the medica	l professional	soon by stud	ont	
# 3	Explain yes answers, include injury, type o	i i eatilielli & tile i	iame of the medica	i professionar	seen by stud	ent	
11.	above consists at beat and the beat of construction of the second of the	- Infano - () 1					
	reby certify that to the best of my knowledge all of the		ein is true and cor	•	D. (,	
	ent's Signature				Date/	_/	-
	reby certify that to the best of my knowledge all of the ent's/Guardian's Signature		ein is true and cor	-	Date/_		_