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.

	SUPP	LEMENTAL	HEALTH	I HISTORY					
Stud	dent's Name					Male/Fe	male (ci	ircle one)	
Date of Student's Birth:/ Age of Student				t on Last Birthday: Grade for Current School Year:					
Win	ter Sport(s):		_Spring S	Sport(s):					
	ANGES TO PERSONAL INFORMATION (In the spaning original Section 1: Personal and Emergency Info			y any changes t	o the Persor	nal Information	on set f	orth in	
Cur	rent Home Address								
Cur	rent Home Telephone # (Pa	rent/Gua	dian Current Cell	ular Phone #	()			
	ANGES TO EMERGENCY INFORMATION (In the she original Section 1: Personal and Emergency In			tify any changes	to the Eme	rgency Infor	mation	set forth	
Parent's/Guardian's Name				Relationship					
Address			Emergency Contact Telephone # ()						
Secondary Emergency Contact Person's Name				Relationship					
Add	lress		Emerge	ency Contact Tele	phone # ()			
Med	dical Insurance Carrier			Po	olicy Number				
Address				Tele	ohone # ()			
Fan	nily Physician's Name					, MD o	r DO (ci	rcle one)	
Add	lress			Telep	hone # ()			
If any SUPPLEMENTAL HEALTH HISTORY quest completed Section 9, Re-Certification by Licensed the student's school. Explain "Yes" answers at the bottom of this form. Circle questions you don't know the answers to. 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 serio marked "Yes", please provide additional informatic. 2. Since completion of the CIPPE, have you		No was	3. 4. 5.	Since completion experienced dizzy sy unconsciousness? Since completion experienced any epi shortness of breath, pain? Since completion taking any NEW prepills?	on of the CIPPI spells, blacko point of the CIPPI episodes of une th, wheezing, a on of the CIPPI prescription me	E, have you uts, and/or E, have you explained ind/or chest E, are you dicines or			
۷.	had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?		6.	Do you have ar like to discuss with		at you would			
#'s	Explain yes answers; include injury, type	of treatmen	nt & the n	ame of the medica	l professional	seen by stud	ent		
_	reby certify that to the best of my knowledge all of t	he informa	ation here	in is true and cor	nplete.				
	reby certify that to the best of my knowledge all of tent's/Guardian's Signature	he informa	ation here	ein is true and cor	mplete.	_Date/		_	