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.

Ctur				HISTORY		Mal	o/Fomolo /a	امعد مامدند
Siuc	dent's Name					iviai	e/Female (d	arcie one)
Date	e of Student's Birth:/ Ag	Grade for C	Grade for Current School Year:					
Win	ter Sport(s):		_Spring S	Sport(s):				
	ANGES TO PERSONAL INFORMATION (In the sportiginal Section 1: Personal and Emergency Info			y any changes to	o the Persor	al Inforn	nation set	forth in
Curr	rent Home Address							
Cur	rent Home Telephone # (Pa	rent/Guai	dian Current Cellu	ular Phone #	()		
	ANGES TO EMERGENCY INFORMATION (In the s			tify any changes	to the Eme	rgency Ir	nformation	set forth
Pare	ent's/Guardian's Name				Relation	onship		
Pare	ent/Guardian E-mail Address:							
Add	ress		Emerge	ency Contact Telep	phone # ()		
Sec	ondary Emergency Contact Person's Name				Relati	onship _		
Add	ress		Emerge	ency Contact Telep	phone # ()		
Med	lical Insurance Carrier			Po				
Address			Telephone # ()					
Fam	nily Physician's Name					, M	ID or DO (c	ircle one)
Add	ress			Telep	hone # ()		
the s Expl Circ 1.	pleted Section 8, Re-Certification by Licensed Physicistudent'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? Idditional note to item #1. if serious illness or serious injury marked "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?	No Vas	3. 4. 5.	Since completic experienced dizzy unconsciousness? Since completic experienced any e shortness of breat pain? Since completic taking any NEW p pills? Do you have an like to discuss with	on of the CIPPI spells, blacko on of the CIPPI spisodes of une h, wheezing, a on of the CIPPI rescription me	E, have youts, and/or E, have yo explained and/or chese, are you dicines or at you wou	Yes u u u u u	No
#'s	Explain yes answers; include injury, type	of treatme	nt & the n	ame of the medical	professional	seen by	student	
I hei	reby certify that to the best of my knowledge all of	the informa	ation here	in is true and con	nplete.			
Stud	lent's Signature					Date	<i>_</i>	_
	reby certify that to the best of my knowledge all of tent's/Guardian's Signature	the informa	ation here	in is true and con	nplete.	Date	1 1	