

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

Section 6: PIAA COMPREHENSIVE PRE-PARTICIPATION PHYSICAL RE-EVALUATION AND RE-CERTIFICATION BY AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by either (1) the AME who performed the initial pre-participation physical evaluation, or (2) another AME who has reviewed the previously completed Sections 1 through 5 of this CIPPE Form. Upon completion and signature, and prior to the student's participation in a second and subsequent sport in the same school year, this Section must be turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name _____ Age _____ Grade _____

Enrolled in _____ School _____ Sport(s) _____

Height _____ Weight _____ % Body Fat (optional) _____ BP _____ / _____ (_____ / _____ , _____ / _____) RP _____

If either the blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended. **Age 10-12:** BP: <126/82, RP: <104; **Age 13-15:** BP: <136/86, RP <100; **Age 16-25:** BP: <142/92, RP <96

Vision R 20/____ L 20/____ Corrected YES NO (circle one) Pupils: Equal ____ Unequal ____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the SUPPLEMENTAL HEALTH HISTORY, performed a physical re-evaluation of the herein named student, and, on the basis of such re-evaluation and the student's SUPPLEMENTAL HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 5 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

CLEARED **CLEARED**, with recommendation(s) for further evaluation or treatment for: _____

NOT CLEARED for the following types of sports (please check those that apply):

COLLISION CONTACT NON-CONTACT STRENUOUS MODERATELY STRENUOUS NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type) _____ License # _____

Address _____ Phone () _____

AME's Signature _____ MD, DO, PAC, CRNP, or SNP (circle one) Date of Re-evaluation ____/____/____