

**SECTION 5: PIAA RE-CERTIFICATION BY PARENT/GUARDIAN**

This form must be completed by the parent/guardian of any student who (1) previously participated in PIAA interscholastic athletic competition pursuant to a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) 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.