

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

**This is not a physical form. This is for those who already had a sports physical for the current academic year and will be going to play a winter or spring sport.** This form should only be completed by the parent/guardian of any student who (1) previously participated in a PIAA interscholastic sport for the current school year and completed a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE) for that sport for the current school year; and (2) is seeking to participate in practices, inter-school practices, scrimmages, and/or contests in a subsequent sport(s) in the same school year. The Certified Athletic Trainer must review the SUPPLEMENTAL HEALTH HISTORY and make a determination as to whether the student should be re-evaluated and re-certified by a licensed physician of medicine or osteopathic medicine.

SUPPLEMENTAL HEALTH HISTORY

Student's Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Winter or Spring Sport to be play: \_\_\_\_\_

**CHANGES TO PERSONAL INFORMATION:** In the spaces below, identify any *changes* to the Personal Information set forth in the original Comprehensive Initial Pre-Participation Examination form. **PLEASE LIST CHANGES ONLY.**

Current Home Address \_\_\_\_\_

Current Telephone # H(\_\_\_\_) \_\_\_\_\_ W(\_\_\_\_) \_\_\_\_\_ C(\_\_\_\_) \_\_\_\_\_

CHANGES TO EMERGENCY INFORMATION

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Phone H(\_\_\_\_) \_\_\_\_\_ W(\_\_\_\_) \_\_\_\_\_ C(\_\_\_\_) \_\_\_\_\_

Emergency Contact 2 \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact 2 Phone H(\_\_\_\_) \_\_\_\_\_ W(\_\_\_\_) \_\_\_\_\_ C(\_\_\_\_) \_\_\_\_\_

Family Physician \_\_\_\_\_ Family Physician Address \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_

SUPPLEMENTAL HEALTH HISTORY: Explain "Yes" answers at the bottom of this form.

*Since your last sports physical:*

	Yes	No		Yes	No
1. Since completion of the CIPPE, have you sustained an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic medicine?	Y	N	4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	Y	N
2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or head injury	Y	N	5. Since completion of the CIPPE, are you taking any NEW prescription or non-prescription medicines or pills	Y	N
3. Since completion of the CIPPE, have you Experienced dizzy spells, blackout, and/or unconsciousness	Y	N	6. Do you have any concerns that you would like to discuss with a doctor?	Y	N

Explain "Yes" answers here: \_\_\_\_\_

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

This Form must be completed for any student who, subsequent to completion of Sections 1 through 4 of the CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 6 may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to the Certified Athletic Trainer.

**NOTE: The physician completing this Form must first review Sections 3 and 4 of the herein named student's previously completed CIPPE Form. Section 5 must also be reviewed if both 1) this Form is being used by the herein named student to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in a subsequent sport season in the same school year AND 2) the herein named student either checked yes or circled any Supplemental Health History questions in Section 5.**

**If the physician completing this form is clearing the herein named student subsequent to that student sustaining a concussion or head injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.**

Student's Name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Enrolled in \_\_\_\_\_ School \_\_\_\_\_

Condition(s) Treated Since Completion of the Herein Named Student's CIPPE Form: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**A. GENERAL CLEARANCE:** Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with no restrictions, except those, if any, set forth in Section 4 of that student's CIPPE Form.

Physician's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ MD or DO (*circle one*) Date \_\_\_\_\_

**B. LIMITED CLEARANCE:** Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with, in addition to the restrictions, if any, set forth in Section 4 of that student's CIPPE Form, the following limitations/restrictions:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Physician's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ MD or DO (*circle one*) Date \_\_\_\_\_