

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

This form must be completed by the parent/guardian of any student who (1) completed a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE) between June 1<sup>st</sup> and participation in the student's first sport season's first Practice of the same school year; 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.

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

Must be completed and signed by an Authorized Medical Examiner and turned in to the Principal, or the Principal's designee, of the student's school prior to participation in second and subsequent sport in the same school year.

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

Enrolled in \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ )

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) \_\_\_\_\_

Authorized Medical Examiner's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

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

Authorized Medical Examiner's Signature \_\_\_\_\_ MD, DO, PAC, CRNP, or SNP (circle one) Date \_\_\_\_/\_\_\_\_/\_\_\_\_