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.

SUPPLEMENTAL HEALTH HISTORY

Student's Name _____ Male/Female (circle one)

Date of Student's Birth: _____/_____/_____ Age of Student on Last Birthday: _____ Grade for Current School Year: _____

Winter Sport(s): _____ Spring Sport(s): _____

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):

Parent's/Guardian'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
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?	☐	☐
2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?	☐	☐
4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	☐	☐
5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills?	☐	☐
6. Do you have any concerns that you would like to discuss with a physician?	☐	☐

#'s	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___/___/____

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___/___/____

(over)

St. Joseph's Catholic Academy
Athletics
Student Information

Last Name:	First Name:	Sport:

Grade:	School:	☐ Male ☐ Female	DOB:

Street Address:	City:	Zip:

Parent/Guardian Emergency Contact Information

Parent/Guardian Name:	Home Phone:	Work Phone:	Cell Phone:

Parent/Guardian Street Address:	City:	Zip:

Other Emergency Contact (Name):	Relationship to Athlete:

Home Phone:	Work Phone:	Cell Phone:

Insurance Information

Provider:	Insurance ID#:	Group Policy #:

Medical History

Facts concerning my child's medical history including allergies, medication and physical impairments to which medical personnel should be alerted:

_____

_____

Date of most recent Tetanus Inoculation:

1. I **DO** give my consent to the certified athletic trainer/coach(es), presently responsible for supervising my child, named above to arrange for medical and dental care inclusive of diagnostic testing whenever in the course of such supervision the Coach/Advisor or any attending physician or other competent medical professional deems such are to be immediately needed for the safety of the child and times does not permit giving personal notice of obtaining personal consent to proceed.
2. I further **DO** give the consent to all emergency medical and dental procedures that are deemed necessary by the attending physician, dentist, or other competent medical professional to preserve his/her life or to prevent impairment of his/her health in the case that time does not permit obtaining my personal consent to these procedures.
3. I, the undersigned student and parents(s) or lawful guardian, do hereby certify that we have read and understand the above consent statements (#1 and #2) and do hereby approve the same.
4. My signature below authorizes SJCA representatives to release and receive information pertaining to my medical record and to any current course of treatment. This includes but is not limited to, physicians, hospitals, other medical facilities and insurance companies. I understand that this information may be transferred orally, electronically, or written,
5. My signature below indicates that I have read and understand the SJCA **Athlete's Handbook**.

_____ _____

Signature of Parent/Guardian Date Signature of Student Date