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 _____

Parent/Guardian E-mail Address:_____

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 # ( )_____

If any SUPPLEMENTAL HEALTH HISTORY questions below 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.
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 a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine?	❑	❑
An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below		
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; include injury, type of treatment & the name of the medical professional seen by student

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____/____/_____

Radnor Township School District
Permission from Parent, Guardian for Medical Treatment

School Year: _____ Sport _____

Last Name	First	Initial	Grade	School District	Student Birthdate
_____	_____	_____	_____	_____	_____

As a parent/guardian I expect every effort will be made to contact me in order to receive my specific authorization before any treatment or hospitalization is undertaken.

Home Phone _____ Father's Work # _____ Mother's Work # _____

Cell # _____ Father _____ Mother_____

Street Address	City	State	Zip
_____	_____	_____	_____

If Parent cannot be reached call:

1._____
Name Tele # relationship

2._____
Name Tele # relationship

In the event of an emergency requiring medical attention, I grant permissison to a physician or other hospital personnel designated by the Radnor coaching staff to attend my son/daughter.

Print Parent/Guardian Name	Signature Parent/Guardian	Date
_____	_____	_____

Family Physician _____ Tele # _____ Dentist _____ Tele # _____

INSURANCE COVERAGE:

You are required to provide medical insurance coverage in order to participate in our interscholastic program. This certifies that my child has proper and adequate coverage.

Insurance Company	Policy No.	Group No.
_____	_____	_____

Subscriber SS #_____ Subscriber Name _____

Does your child wear: contacts/ glasses Has you child ever had: asthma/ diabetes / kidney injury / heart condition
If yes, please explain: _____

Is your child allergic to any medication? _____

Is there any condition other than stated above, that a physician should be aware of? _____

Has your child ever repeated a grade after 6th grade: (circle) 7th 8th 9th 10th 11th 12th

White - Coach Canary - Trainer Pink - Athletic Dept.

RTSD-124 NCR