



Fred S. Engle Middle School  
Athletic Department  
2009-2010

PIAA Re-Certification by Parent/Guardian

Section 5 - PIAA Re-Certification by Parent/Guardian form is attached. This form is to be completed if the athlete has already completed a PIAA Medical Packet, has a PIAA Comprehensive Initial Pre-Participation Physical Evaluation and Certification of Physician (CIPPE) completed since June 1, 2009, on file in the athletic office, and is interested in competing in a subsequent sport; or if you are submitting a new CIPPE packet and the date of the original physical is more than 6 weeks prior to March 8, 2010. **The Re-Certification must be filled out and signed within 6 weeks of the first practice or tryout.**

A completed PIAA Medical Packet, CIPPE and a PIAA Re-Certification by Parent/Guardian must be on file in the athletic office **BEFORE** the athlete is eligible to participate in any practice or tryout for any interscholastic sport or any cheerleading squad.

**Baseball, Softball, Track and Field and Girls' lacrosse will start March 8, 2010.**

If you are not sure if you have an updated PIAA physical form on file in the athletic office or if you need to have a re-certification, or if you have any other questions concerning your child's sports physical, please do not hesitate to call the athletic office at 610-869-3022, Ext. 3483.

**SECTION 5: 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 6, 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.**

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|--|---|
| <p>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? <span style="float: right;">Yes No</span></p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></p> <p>2. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? <span style="float: right;">Yes No</span></p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></p> | <p>3. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? <span style="float: right;">Yes No</span></p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></p> <p>4. Since completion of the CIPPE, are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills? <span style="float: right;">Yes No</span></p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></p> <p>5. Do you have any concerns that you would like to discuss with a physician? <span style="float: right;">Yes No</span></p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></p> |
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No(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 \_\_\_\_/\_\_\_\_/\_\_\_\_