SECTION 8: 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 9, 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 # ( )_____

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 9, 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____/____/_____

HUNTINGDON AREA SCHOOL DISTRICT

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I, _____(parent/guardian), as the parent/guardian of _____, a student-athlete, understand that participation in athletic activities may result in injury. I also understand that when injuries arise, immediate action must be taken. In order to secure immediate care/treatment for _____, certain protected health information/personally identifiable information may need to be released by School District representatives to medical personnel.

By signing this form, I hereby authorize the School District's physicians, athletic trainers and other healthcare personnel to disclose _____'s protected health information to other healthcare providers, hospitals, medical clinics, laboratories, medical insurance coordinators, athletic coaches and the School District's Administration. Disclosures may include information pertaining to a specific injury, illness, or medical condition, or the student's medical status, prognosis, diagnosis, and other protected health information.

This authorization is only valid for the _____ school year. I understand that I have the right to revoke this authorization prior to the conclusion of the school year by submitting written notification to the Athletic Director.

_____ Date:_____

Name of Student

_____ Date:_____

Signature of Parent

FOR TREATMENT OF MINORS

IN THE EMERGENCY/OUTPATIENT DEPARTMENT

AND HIGH SCHOOL ATHLETIC DEPARTMENT

In the event that I am unavailable for purposes of providing parental consent, I hereby authorize the physician(s) and staff in the Emergency/Outpatient Department of the treating hospital to provide such hospital care that includes routine diagnostic procedures and medical treatment as necessary to my minor son/daughter.

Student's Name: _____

I also hereby authorize the Athletic Training and coaching staffs to provide any emergency first aid care as is deemed necessary.

I understand that the consent and authorization herein granted does not include major surgical procedures.

This consent is valid for one year from the date indicated below. A photocopy of this authorization shall be considered as effective and valid as the original.

Physical conditions of the minor noted above that the physician should be aware of (allergies, recurring illnesses, disabilities, chronic illnesses, medications, and date of last immunizations, etc.)

Allergies: _____

Medications: _____

Other: _____

I understand that I will be contacted as soon as possible in the event that my child is brought to the hospital for treatment. If I am not available, please contact:

Name: _____ Phone: _____

I also consent to the release of a report containing diagnoses and other medical information related to the examination and treatment of the above patient to such agencies, including insurance companies, as might be concerned with payment of charges for hospital services.

_____
Insurance Provider

_____
Policy Number

_____
Parent/Guardian Signature

_____ _____
Date Relationship

_____
Address

_____

_____
Telephone: Work/Home