

COUNCIL ROCK SCHOOL DISTRICT RE-CERTIFICATION BY PARENT/GUARDIAN

(Please read the following instructions carefully to avoid having your forms rejected)

RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed by the parent/guardian of any student who (1) previously participated in PIAA interscholastic athletic competition pursuant to a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); 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.

***Note* if you answer YES to any question SECTION 4: must be completed and signed by an authorized medical examiner.**

SECTION 4: PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Once your Authorized Medical Examiner has completed the pre-participation physical they should note any concerns in the appropriate section. **They must then select your athlete's level of clearance, sign, and date the form. Electronic signatures on the physicians office form are NOT acceptable. The physicals for the school calendar year may not be completed any earlier than June 1st.**

These forms should be handed into the coach no later than the first day of practice. If an athlete shows up for the first day of practice without these forms completed correctly they will not be allowed to participate until they are.

QUESTIONS?

If your child is attending one of the high schools, questions regarding the pre-participation packet should be directed as follows: Physical and medical history questions should be directed to the athletic trainer at your school, CR-North at 215-944-1368 or CR-South at 215-944-1185. Questions about any other part of the packet should be directed to the athletic department at your school, CR-North 215-944-1314 or CR-South 215-944-1103.

If your child is attending one of the middle schools, and you have any questions about the pre-participation packet, please contact the Athletic Office at your school.

Newtown - (215) 944-2615

Holland – (215) 944-2700

Richboro – (215) 944-2515

SECTION 4: PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF PHYSICIAN

*****Must be completed and signed by an authorized medical examiner.*****

Name _____ Age _____

Enrolled in _____ School Sport(s) _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____/____ (____/____) (____/____)

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		
Cardiopulmonary		
Lungs		
Abdomen		
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 and further certify that the student does not have any communicable illness or condition, which would pose a danger to teammates and/or competitors:

Cleared Cleared after completing evaluation/rehabilitation 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) _____

Name of physician (print/type) _____ License # _____

Address: _____ Telephone: _____

Signature of physician _____ MD/OD (circle one) Date _____