

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 _____

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

An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below

#'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 ____/____/____

Section 9: Re-CERTIFICATION BY LICENSED PHYSICIAN OF MEDICINE OR OSTEOPATHIC MEDICINE

This Form must be completed for any student who, subsequent to completion of Sections 1 through 6 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 9 may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to the Principal, or the Principal's designee, of the student's school, who, pursuant to ARTICLE X, LOCAL MANAGEMENT AND CONTROL, Section 2, Powers and Duties of Principal, subsection C, of the PIAA Constitution, shall "exclude any contestant who has suffered serious illness or injury until that contestant is pronounced physically fit by the school's licensed physician of medicine or osteopathic medicine, or if none is employed, by another licensed physician of medicine or osteopathic medicine."

NOTE: The physician completing this Form must first review Sections 6 and 7 of the herein named student's previously completed CIPPE Form. Section 8 must also be reviewed if both (1) this Form is being used by the herein named student to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in a subsequent sport season in the same school year AND (2) the herein named student either checked yes or circled any Supplemental Health History questions in Section 8.

If the physician completing this Form is clearing the herein named student subsequent to that student sustaining a concussion or traumatic brain injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.

Student's Name: _____ Age _____ Grade _____

Enrolled in _____ School _____

Condition(s) Treated Since Completion of the Herein Named Student's CIPPE Form: _____

A. GENERAL CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with no restrictions, except those, if any, set forth in Section 7 of that student's CIPPE Form.

Physician's Name (print/type) _____ License # _____

Address _____ Phone () _____

Physician's Signature _____ MD or DO (circle one) Date _____

B. LIMITED CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with, in addition to the restrictions, if any, set forth in Section 7 of that student's CIPPE Form, the following limitations/restrictions:

1. _____
2. _____
3. _____
4. _____

Physician's Name (print/type) _____ License # _____

Address _____ Phone () _____

Physician's Signature _____ MD or DO (circle one) Date _____

Solanco School District

Interscholastic Athletic Participation and Student Parking Contract

Solanco School District allows students to participate in interscholastic athletic activities and use school parking facilities. Participation in such activities is a privilege, not a right, and carries additional responsibilities. The following regulations apply to any student involved in interscholastic athletic activities or obtaining a student parking permit.

I, _____, agree to refrain from using, possessing or distributing alcohol, drugs, prescriptive drugs inconsistent with the physician’s directive and related paraphernalia on and off school grounds.

I, _____, agree to participate in any survey conducted by the District as required by the state or federal government associated with this drug testing policy.

I have read Policy 227.2, entitled “Drug Testing for Students Participating in Interscholastic Athletics and Student Drivers.” The policy is available at the District website at Solancosd.org, and hard copies are available at each school office. I understand my responsibilities regarding my behavior in terms of these policies and the potential sanctions for violating these policies.

As the parent/guardian of _____, I do hereby give my permission to allow my child to participate in the interscholastic athletic activities of Solanco School District during the 20__/20__ school year. I have ready Policy 227.2 entitled, “Drug Testing for Students Participating in Interscholastic Athletics and Student Drivers,” and understand the student will be subject to these terms throughout the entire year and the potential sanctions for violations of these policies.

Method selection: The Solanco School District provides parents/guardians and students with a choice to submit either a urine or hair specimen for drug testing purposes. Parents/guardians and students must elect to have either a urine or hair specimen collected for drug testing when making this choice. That choice will remain in place for the entire school year. No students will be permitted to change their elected specimen method during the upcoming school year; however, a change may be made in subsequent school years.

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PLEASE SEE THE BOTTOM OF THIS PAGE FOR AN EXPLANATION OF THE DRUG TESTING OPTIONS BEFORE SELECTING PREFERRED METHOD.

Method Selected (Circle One) Hair Sample OR Urine Sample

Consent to Drug Testing: As the parent/guardian of _____, I give permission for the Solanco School District and its designated testing facility to have my son/daughter participate in the mandatory random drug testing program described in Policy 227.2. By signing this document, I also consent, pursuant to the Family Educational Rights and Privacy Act, to release information about the drug test results to certain individuals identified in Policy 227.2. Mandatory random testing shall be conducted without prior student or parent/guardian warning.

Student Signature

Date

Parent/Guardian Signature

Date

The different specimen drug testing options can be briefly summarized as follows:

Urine Specimen: A student selected for drug testing will be called to the nurses’ office. A screening technician will escort the student to the testing room. The student is alone in the testing room and will provide the urine specimen. After providing the urine specimen, the screening technician verifies the temperature of the urine specimen as indicated by the temperature on the label of the urine specimen and double seals the urine specimen container. The student is then asked to sign a chain of custody form indicating the student gave his/her urine specimen directly to the screening technician.

Hair Specimen: A student selected for drug testing will be called to the nurse’s office. A screening technician will accompany the student to the testing room to obtain a hair specimen. The screening technician will cut approximately one hundred (100) strands of hair from the student’s head to collect the specimen. The hair specimen will be placed in a hair specimen container. The student will be asked to sign a chain of custody form indicating the student gave his/her hair specimen directly to the screening technician.

There are differences between urine and hair specimen drug testing. The presence of illegal drugs can typically be detected over a longer time period using hair samples, while urine sample testing can more easily detect more recent illicit drug use. You will need to consider these facts and the potential privacy concerns associated with hair or urine specimen submission when selecting a drug testing option.