



Bellefonte Area School District
Section 7: Re-Certification By Parent/Guardian Form

If you participated in a Fall sport and plan on participating in a Winter sport you must pick up, complete and return a SECTION 7 PIAA RE-CERTIFICATION BY PARENT/GUARDIAN form by Friday, October 26th, 2018. Failure to turn in a repeat/recertification form will result in your inability to participate in Winter Athletics.

Completed Section 7: Re-certification forms should be turned in to the Athletic Trainer by FRIDAY, OCTOBER 26th, 2018.

After completing and turning in your SECTION 7 re-certification form you will be contacted only if you need to report for a follow up doctor visit.

Forms are available in the High School, Middle School main offices, the high school training room, and on-line off the BASD Athletics web page.

If you have any questions or request further information, please contact the Athletic Office - 353-5322.

PARENT INFORMATIONAL MEETING – Thursday, November 1st in the HS Cafeteria at 6:00 pm. It is imperative that one representative from each student athletes family be present at this meeting.

The first day of Fall Sports is Friday, November 16th, 2018.

All repeat athlete forms are due to the Athletic Trainer by Friday, October 26th, 2018.



STUDENT ATHLETE DEMOGRAPHICS

Last Name: _____ First Name: _____ MI: _____

Date Of Birth: _____ Current Age: _____ District Enrollment Date: _____

Place of Enrollment: (____) BAHS (____) BAMS OTHER: (i.e. – Cyber, Charter, Home) _____

Grade for the 2018-2019 School Year: 7th 8th 9th 10th 11th 12th

Have you repeated any grades since 7th grade? YES NO

If so, which grade(s)? _____

Please indicate which sport below: (i.e.: Girls Soccer, Boys Basketball, Track and Field)

FALL Sport: _____ WINTER Sport: _____ SPRING Sport: _____

Which years have you competed in this sport for BASD? 7th 8th 9th 10th 11th 12th

Which years at another PIAA school district? N/A 7th 8th 9th 10th 11th 12th

District: _____

Parent Name: _____ Email: _____ Cell: _____ Relationship: _____

Parent Name: _____ Email: _____ Cell: _____ Relationship: _____

BELLEFONTE ATHLETE HANDBOOK SIGN-OFF

The current Athlete Handbook is available on-line. Go to the Bellefonte Area School District web site; from there go to the Athletic web page and the link to the handbook is located on the left side of the page.

By signing below, I confirm that I have read and understand the current Athlete Handbook for the Bellefonte Area School District.

(Parent/Guardian Name)

(Signature)

(Date)

(Athlete's Name)

(Signature)

(Date)

Check here if you would like a paper copy of the current handbook.



BELLEFONTE AREA SCHOOL DISTRICT
CONSENT FOR EMERGENCY MEDICAL TREATMENT

Athlete's name: Birthdate: Grade: Date:

In the event of an emergency requiring medical attention, I expect every measurable attempt be made to contact me. In case I cannot be reached, I grant permission for any immediate treatment deemed necessary by the attending physician, dentist, or other medical personnel designated by the Bellefonte Area School District's Sport's Medicine staff to attend to my child. I expect every effort will be made to contact me in order to receive my specific authorization before any treatment or hospitalization is undertaken.

This authorization does not cover major surgery unless formally decreed prior by two licensed physicians or dentists.

Facts concerning my child's medical history including allergies, medications being taken and physical impairments to which medical personnel should be alerted to:

Check One: I GIVE MY CONSENT OR I DO NOT GIVE MY CONSENT

Parent/Guardian Signature: Cell:
Address Home Phone:
Bus. Phone:

In the event emergency treatment is required, I wish medical personnel to take the following action:
Dr.: Ph:
Dentist: Ph:
Emergency Contact(s):
Name: Relationship: Phone:

BELLEFONTE AREA SCHOOL DISTRICT
MEDICAL INSURANCE INFORMATION AND WAIVER

This is to certify that my son/daughter a student at the Bellefonte Area Schools, who is participating in the interscholastic athletic program, is covered with medical insurance under my personal policy or at my place of employment. (Note: Please check to determine that your hospitalization will cover participation in interscholastic sports, if your child is not covered by an insurance policy the district recommends the purchase of school insurance.) I hereby waive any claim against the Bellefonte Area School District resulting from failure of the District to cover him/her with such medical insurance and assume all liability therefore.

I certify that my son/daughter is covered with medical insurance for the period of to and have signed and completed requested insurance information.

My son/daughter is not covered by medical insurance at this time, however in the event that coverage is obtained I will notify the Athletic Trainer and provide the appropriate insurance information. (Parent/Guardian signature and date needed on following line.

Parent/Guardian Signature: Date:

Insurance Company: Employer:

Insurance Policy Number:

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 _____

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.

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 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? | <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"/> |
| 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"/> | 5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills? | <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"/> | 6. Do you have any concerns that you would like to discuss with a physician? | <input type="checkbox"/> | <input type="checkbox"/> |

#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 ____/____/____