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

If you participated in a Fall and/or Winter sport during the 2018-2019 school year and plan on participating in a Spring sport you must pick up, complete and return a SECTION 7 PIAA RE-CERTIFICATION BY PARENT/GUARDIAN form by Friday, February 22nd, 2019. Failure to turn in a repeat/recertification form will result in your inability to participate in Spring Athletics.

Completed Section 7: Re-certification form and demographic sheets should be turned in to the Athletic Trainer by Friday, February 22nd, 2019.

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* – Monday, February 11th 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 Spring Sports is Monday, March 4, 2019.

All repeat athlete forms are due to the Athletic Trainer by Friday, February 22nd, 2019.

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 BA SD? 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 herby 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:*____

ACKNOWLEDGEMENT OF RISK

As with any physical activity, I am aware that with the participation in sports there lies a potential risk of injury. I am aware that giving consent to my child for participation in the interscholastic athletic program there is a risk of injury to my child and this risk increases with participation in contact sports.

I acknowledge and accept the risks inherent in my child's sport(s) and with the travel involved. With this knowledge in mind, I grant permission for my child to participate in the Bellefonte Area School District's interscholastic athletic program.

Parent/Guardian Signature: ____

I have read the above paragraphs and fully understand the content and agree to take on the responsibility to follow the coach or athletic trainer's instructions in order to reduce the possibility of serious injury.

Student Athlete's Signature:____

I, the undersigned and legal guardian of____, acknowledge and understand that as a member of one of the Bellefonte Area School District sports teams that student-athletes being dismissed early from school for events may walk on School Street between the Middle School and High School without school personnel supervision.

Student-athletes are to exit their respective building through the main entrance. Upon exiting, they are to walk directly from the Middle School to the High School or vice-versa with no stops along the way. Student-athletes should use the sidewalks and pedestrian walkways obeying traffic rules.

______________________________________	____________________________
Signature of Parent	Date
______________________________________	____________________________
Signature of Student-athlete	Date

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.

	Question	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?	☐	☐
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 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 ____/____/_____