



Rev. G. Scott Shaffer  
Director

Dr. Edward G. Gere  
Principal

Kathleen D'Andrea  
Vice Principal

RECERTIFICATION FORM

Name: \_\_\_\_\_

Sport: \_\_\_\_\_ Grade in Sept. \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Since the student's most recent physical exam:

Did your child receive treatment for illness or injury? Yes\_\_ No\_\_

Does your child have any restrictions due to injury? Yes\_ No\_\_

If yes, did the physician give a note of permission

to return to sports? Yes\_\_\_\_\_ No\_\_\_\_\_

Do you feel that your child is physically able to

participate in this sport? Yes\_\_\_\_\_ No\_\_\_\_\_

Does your child take daily medications? Yes\_\_\_\_\_ No\_\_\_\_\_

Please list: \_\_\_\_\_

Does your child carry an EpiPen or Auvi-Q for allergies? Yes\_\_ No\_\_\_\_\_

If yes, does your child know how to administer it? Yes\_\_\_\_\_ No\_\_\_\_\_

What is your child allergic to? \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_