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:	AgeGrade	
Enrolled in	Sc	hool
Condition(s) Treated Since Completion of the Herein Named Stu	dent's CIPPE Form:	
A. GENERAL CLEARANCE: Absent any illness and/or injurdate set forth below, I hereby authorize the above-identified sturyear in additional interscholastic athletics with no restrictions, exCIPPE Form.	dent to participate for the remainder of the current so	chool
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, we set forth below, I hereby authorize the above-identified student in additional interscholastic athletics with, in addition to the re CIPPE Form, the following limitations/restrictions:	o participate for the remainder of the current school	year
1		
2		
3		
4		
Physician's Name (print/type)	License #	
Address	Phone ()	
Physician's Signature	MD or DO (circle one) Date	