Cecil County Public Schools Interscholastic Athletics

This packet is used for <u>ALL</u> MIDDLE & HIGH SCHOOL sports.

Name (Last):	(First):		
Grade: School:	Date Completed:		
Packet Contents:	Page #		
Medical History Form (to be completed by parent <u>BEFORE</u> phys Athletic Physical Examination Form - to be completed by physici	, ,		
- Parents must sign this form AFTER the doctor completes the	ne physical exam2		
Parent's Permission for Care and Insurance Signature Form	3		
Concussion & Sudden Cardiac Arrest Information / Permission to Participate			
COVID-19 Awareness Acknowledgement Statements	5		
Separate Items:			
Emergency Card (inserted in package or handed to you for comp	oletion by parent) Insert		
Keep this packet together and return it all to the coach when complete.			
Be sure you have SIGNED next to any place in the booklet that has this symbol. Parent's signature must be on ALL forms <u>prior</u> to participation. If you have any questions, please contact your child's school.			

RETURN THIS ATHLETIC FORMS PACKET TO YOUR SCHOOL

Cecil County Public Schools Interscholastic Athletics MEDICAL HISTORY FORM (PARENT'S SECTION) (Grades 6-12)

Nar	ne:								DOB:			
Sex	:: M / F	Age:	Grade: _		_	Scho	ol:					
Chil	ld's Physicia	ın:					Pł	none:				
DIR	ECTIONS: P	lease check box	for "Yes" or "No" ar	ıd expla	in "Yes	" ans	wers in	the space b	elow.			
1.	Have you ever last check up o	had a medical illness or sports physical?	or injury since your	YE S	NO	20.	Have you hands, leg	ever had num s, or feet?	nbness or tingling i	·	YE S	NO
2.	(over-the coun	tly taking a prescription ter) medications?					or after ac	tivity?	or have trouble bre	athing during		
3.		been hospitalized ove				22.		ve asthma?				
4.	medicine, food	ny allergies (for examp , or stinging insects)?	•			23.	treatment?	•	allergies that req	uire medical		
5.	exercise?	passed out or been di	•			24.	Do you ha	ve diabetes? U	lse insulin?			
6.	Have you ever	had chest pain during	or after exercise?			25.	Do you los		arly to meet weight	requirements		
7.	Have you ever	become ill from exerci	sing in the heat?			26.			rotective or corrective			
8.	Have you ever heartbeats?	had racing of your hea	art or skipped				(for examp		, special neck roll, f			
9.	Have you had	high blood pressure or	high cholesterol?			27.		ever had any pr ses or contacts	roblems with your e	yes or vision?		
10.	Have you ever lost your memo		come unconscious, or			28.	Have you	ever been told	you have a heart m	urmur?		
11.	Has any family or of sudden de	member or relative die eath before age 50?	ed of heart problems			29.	Have you	ever had a spra	in, strain, or swellin	g after injury?		
12.	Have you had	a severe viral infection mononucleosis) within				30.	Have you joints?	broken or fractu	ured any bones or d	islocated any		
13.	Has a physicia	n ever denied or restrictly heart problems?				31.			problems with pain es, or joints? If			
14.	Do you have a	ny current skin problen , acne, warts, fungus, o						e area and exp		,		
15.	Have you ever	had a head injury or c	oncussion?			Head Fore		Elbow Thigh	Hip Back	Neck Wrist	Foot Knee	
16.	Have you ever	had a stinger, burner,	or pinched nerve?			Ches Shou	it	Hand Finger	Shin/Calf Ankle	Upper Arm	TUIOO	
17.	Have you ever	had a seizure?				32.	Do you h	ave any comm	unicable diseases?			
18.	Do you have fr	equent or severe head	aches?			33.	Do you h	ave Marfan's S	Syndrome?			
19.	Do you have s					34.	Are you	easily fatigued?	?			
Evn	lain "Vae" and	wers on an addition	nal shoot									

Explain "Yes" answers on an additional sheet. By signing below,

- I understand and agree that student athletes are not to use tobacco, alcohol, or other drugs at any time. (Reference: Interscholastic Regulations, Policies, and Procedures Handbook) Any substantiated reported use of alcohol, tobacco, or other drugs in school will be handled in accordance to county policy.
- I understand that my student athlete's participation in the FREE pre-participation physical examination (PPE) does not establish a patient-physician relationship. The PPE is solely for safe athletic participation and does not replace an annual well-child exam.
- I authorize the medical providers and staff from Union Hospital of Cecil County, Inc., ATI Physical Therapy, and the community-based private practices,
 participating in the Cecil County Sports Physicals, to render a physical examination, and/or assist in rendering a physical examination, on my student
 athlete.
- I also hereby state that to the best of my knowledge, my answers to the above questions are complete and correct. I give my consent for the above named student to engage in interscholastic sports activities as a representative of their school except those activities crossed out by the examining physician on the reverse side of this form.

Read above paragraph before signing consent form. <u>SIGN PRIOR TO OBTAINING PHYSICAL</u> and be sure to give this to the doctor performing the physical evaluation.

(2)	
C. Hens	Signature of Student Athlete
Signitive	
Date Signed:	Signature of Parent/Guardian

YOUR SCHOOL

Cecil County Public Schools ATHLETICS PHYSICAL EXAMINATION FORM

BLOOD PRESSURE	
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					4	
Patient's Name:			DOB:	Height:	Weight:	
Vision: R 20/	L 20/	Corrected?	Yes No	Pupils: Equal	Unequal	
MEDIC	CAL	NORMAL	AE	NORMAL FINDINGS	INITIAL	S
Appearance						
Eyes/Ears/Nos	se/Throat					
Lymph Nodes						
Heart						
Pulses						
Lungs						
Abdomen						
	SKELETAL	NORMAL	ΔΕ	NORMAL FINDINGS	INITIAL	S
Neck						
Back						
Shoulder/Arm						
Elbow/Forearm	1					
Wrist/ Hand	-					
Hip/Thigh						
Knee						
Leg/Ankle						
Foot						
					<u>.</u>	
sports listed	below which are	NOT crossed out.			ete in the interscholas	<u>otic</u>
	•	Field Hockey			Lacrosse	
Soccer	Baseball	Softball	Tennis	Track & Fie	eld Volleyball	
Wrestling	Cross Country	Воссе	Bowlin	ng Flag Footb	all Marching Band	
This student i	s physically able to	work in the "Constru	ction Field	" at the School of Tech	nology YES	NO
NOT Cleared	Reason/ Recomi	mendations:				
Name of physic	cian and Office (print	/type):				
Address:				Office P	hone:	
Signature of At	tending Physician			D + 0:	ned:	
				Date Sig		
TO BE SIGNE	D DV DADEUT AET		00MDL ET	-n		
TO BE SIGNE I HAVE ON TH	D DV DADEUT AET		00MDL ET	-n		
TO BE SIGNE I HAVE ON TH Date Signed:	D DV DADEUT AET		00MDL ET	-n	THIS FORM.	

CARE AUTHORIZATION

I give my consent for the Certified Athletic Trainer (ATC), within the scope of their training and certification, to render immediate care to my child in the event of a medical emergency and to evaluate and treat non-emergency sport-related injuries and health problems (at practices, contests, and in the athletic training room).

They may dispense equipment and supplies (e.g., crutches, braces, compression wraps, etc.) as may be required for the prevention or treatment of sport-related injuries and communicate to my child and my child's coach(es) such medical information as pertains to my child's readiness to participate safely in athletics. They may share medical information with only other health care providers (e.g. my pediatrician or family physician, specialists, physical therapists, other athletic trainers, etc.) as appropriate.

The foregoing consents will remain valid unless, and until, written notification to the contrary is made by me. I may revoke them at any time.

Parent/Guardian	Signature:	
	Date:	Signitere

HEALTH INSURANCE

I KNOW THAT MY CHILD MUST BE COVERED BY HEALTH INSURANCE TO PARTICIPATE IN ANY CCPS ATHLETIC PROGRAM. MY SIGNATURE VERIFIES THAT MY SON/DAUGHTER IS COVERED BY EITHER PRIVATE HEALTH INSURANCE OR SCHOOL PURCHASED INSURANCE.

<u>Further</u>, in the event of an accidental injury sustained by my daughter/son while in the Interscholastic Athletic Program, I/we shall save harmless the Board of Education, the school and its staff from any liability. <u>Also, I/we will inform the school in writing if my/our insurance is terminated.</u>

Parent/Guardian	Signature:	
	Date:	Signitere

CONCUSSION & SUDDEN CARDIAC ARREST INFORMATION

State law requires that all parents and athletes be made aware of the dangers a concussion may have on an athlete. Cecil County Public Schools is providing concussion information sheets for both parents/guardians and athletes to review **before** participation may occur. This information is also available on the CCPS website.

MY SIGNATURE I	BELOW VERIFIES THAT:				
ı	the parent/guardian of				
(Par	ent/Guardian Printed)	(Name of Student-Athlete Printed)			
	t I have received and read the information provided	about concussions:			
the signs	tion of a concussion and symptoms of a concussion to observe for or the Ip my athlete prevent a concussion	nat may be reported by my athlete			
away, kee	o if I think my athlete has a concussion, specifically p my athlete out of play, tell the coach about a recest to the school nurse				
	t I have received and read the information provided	about <u>Sudden Cardiac Arrest</u> :			
descriptionwarning s					
•	eturn-to-play				
PARENT PERMISSION TO PARTICIPATE BY SIGNING BELOW I GIVE MY SON/DAUGHTER PERMISSION TO PARTICIPATE. I have read all of the statements in this packet					
and have received	the Student and Parent Concussion Information n Sheet, and any school-related expectations. I here	Sheets, the Sudden Cardiac Arrest			
Student Athlete	Signature:	_			
	Date:				
		Signitteredation			
Parent/Guardian	Signature:	_			
	Date:				