Cecil County Public Schools
Interscholastic Athletics

This packet is used for ALL MIDDLE & HIGH SCHOOL sports.

Name (Last): ____________________________  (First): ____________________________
Grade: _________  School: ____________________________  Date Completed: ____________________________
Sport(s): ____________________________________________

Packet Contents:                                      Page #
Medical History Form (to be completed by parent BEFORE physical and given to physician) --------------- 1
Athletic Physical Examination Form - to be completed by a physician- Dated on or after June 1
  - Parents must sign this form AFTER the doctor completes the physical exam ------------------------ 2
Parent’s Permission for Care and Insurance Signature Form ------------------------------------------- 3
Concussion & Sudden Cardiac Arrest Information / Permission to Participate -------------------------- 4

Separate Items:
Emergency Card (inserted in package or handed to you for completion 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 prior to participation.
If you have any questions, please contact your child's school.

RETURN THIS
ATHLETIC FORMS PACKET
TO YOUR SCHOOL

Revised April 2023 (white copies)
Cecil County Public Schools Interscholastic Athletics

MEDICAL HISTORY FORM (PARENT’S SECTION) (Grades 6-12)

Name: ___________________________ DOB: ____________
Sex: M / F Age: ___________ Grade: ________ School: ____________

Child’s Physician: ___________________ Phone: ________________________________

DIRECTIONS: Please check box for "Yes" or "No" and explain "Yes" answers in the space below.

1. Have you ever had a medical illness or injury since your last check up or sports physical? [YES NO]
2. Are you currently taking a prescription or non-prescription (over-the-counter) medications? [YES NO]
3. Have you ever been hospitalized overnight? [YES NO]
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? [YES NO]
5. Have you ever passed out or been dizzy during or after exercise? [YES NO]
6. Have you ever had chest pain during or after exercise? [YES NO]
7. Have you ever become ill from exercising in the heat? [YES NO]
8. Have you ever had racing of your heart or skipped heartbeats? [YES NO]
9. Have you had high blood pressure or high cholesterol? [YES NO]
10. Have you ever been knocked out, become unconscious, or lost your memory? [YES NO]
11. Has any family member or relative died of heart problems or of sudden death before age 50? [YES NO]
12. Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month? [YES NO]
13. Has a physician ever denied or restricted your participation in sports for any heart problems? [YES NO]
14. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? [YES NO]
15. Have you ever had a head injury or concussion? [YES NO]
16. Have you ever had a stinger, burn, or pinched nerve? [YES NO]
17. Have you ever had a seizure? [YES NO]
18. Do you have frequent or severe headaches? [YES NO]
19. Do you have sickle cell trait? [YES NO]
20. Have you ever had numbness or tingling in your arms, hands, legs, or feet? [YES NO]
21. Do you cough, wheeze, or have trouble breathing during or after activity? [YES NO]
22. Do you have asthma? [YES NO]
23. Do you have seasonal allergies that require medical treatment? [YES NO]
24. Do you have diabetes? Use insulin? [YES NO]
25. Do you lose weight regularly to meet weight requirements for your sport? [YES NO]
26. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? [YES NO]
27. Have you ever had any problems with your eyes or vision? Wear glasses or contacts? [YES NO]
28. Have you ever been told you have a heart murmur? [YES NO]
29. Have you ever had a sprain, strain, or swelling after injury? [YES NO]
30. Have you broken or fractured any bones or dislocated any joints? [YES NO]
31. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If "Yes", circle appropriate area and explain below:
---
32. Do you have any communicable diseases? [YES NO]
33. Do you have Marfan’s Syndrome? [YES NO]
34. Are you easily fatigued? [YES NO]

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. SIGN PRIOR TO OBTAINING PHYSICAL and be sure to give this to the doctor performing the physical evaluation.

Signature of Student Athlete ____________________________ Date Signed: ________________
Signature of Parent/Guardian ____________________________

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Cecil County Public Schools
ATHLETICS PHYSICAL EXAMINATION FORM

Patient’s Name: ___________________________ DOB: ___________ Height: ________ Weight: ________

Vision: R 20/ _____ L 20/ _____ Corrected? Yes No Pupils: Equal _____ Unequal _____

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<td>Wrist/ Hand</td>
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<td>Foot</td>
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Beighton-Horan Laxity Screen Score: ___________________________ (Out of 9)

CLEARANCE: I have on this date, personally examined this pupil, reviewed the history and other data recorded on both sides of this form. I find this student physically able to compete in the interscholastic sports listed below which are NOT crossed out.

Basketball  Cheerleading  Field Hockey  Football  Golf  Lacrosse
Soccer  Baseball  Softball  Tennis  Track & Field  Volleyball
Wrestling  Cross Country  Bocce  Bowling  Flag Football  Marching Band

This student is physically able to work in the "Construction Field" at the School of Technology YES NO

NOT Cleared  Reason/ Recommendations: ____________________________________________

Name of physician and Office (print/type): __________________________________________

Address: ___________________________ Office Phone: ___________________________

Must be dated on or after JUNE 1.

Signature of Attending Physician: ______________________ Date Signed: _______________

TO BE SIGNED BY PARENT AFTER THE PHYSICAL IS COMPLETED.

I HAVE ON THIS DATE REVIEWED THE INFORMATION RECORDED ON BOTH SIDES OF THIS FORM.

Date Signed: ________________ Signature of Parent/Guardian: ______________________

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CARE AUTHORIZATION FOR HIGH SCHOOL ATHLETES

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 HIGH SCHOOL 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: ____________________________

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.**

Further, 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. **Also, I/we will inform the school in writing if my/our insurance is terminated.**

Parent/Guardian Signature: ____________________________
Date: ____________________________
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 BELOW VERIFIES THAT:

I ______________________________ the parent/guardian of ______________________________
(Parent/Guardian Printed) (Name of Student-Athlete Printed)

Acknowledge that I have received and read the information provided about concussions:
- the definition of a concussion
- the signs and symptoms of a concussion to observe for or that may be reported by my athlete
- how to help my athlete prevent a concussion
- what to do if I think my athlete has a concussion, specifically, to seek medical attention right away, keep my athlete out of play, tell the coach about a recent concussion, and/or report symptoms to the school nurse

Acknowledge that I have received and read the information provided about Sudden Cardiac Arrest:
- description
- warning signs
- removal/return-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 Sheets, the Sudden Cardiac Arrest Parent Information Sheet, and any school-related expectations. I hereby give my written consent.

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<thead>
<tr>
<th>Student Athlete</th>
<th>Signature: ______________________________</th>
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<th>Parent/Guardian</th>
<th>Signature: ______________________________</th>
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