Cecil County Public Schools

Interscholastic Athletics

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

Name (Last): _____ **(First):** _____

Grade: _____ **School:** _____ **Date Completed:** _____

Packet Contents: **Page #**

Separate Items:

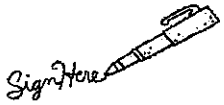
Emergency Card (inserted in package or handed to you for completion by parent) ---------- Insert

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 March 2019 (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.

		YES	NO
1.	Have you ever had a medical illness or injury since your last check up or sports physical?		
2.	Are you currently taking a prescription or non-prescription (over-the counter) medications?		
3.	Have you ever been hospitalized overnight?		
4.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		
5.	Have you ever passed out or been dizzy during or after exercise?		
6.	Have you ever had chest pain during or after exercise?		
7.	Have you ever become ill from exercising in the heat?		
8.	Have you ever had racing of your heart or skipped heartbeats?		
9.	Have you had high blood pressure or high cholesterol?		
10.	Have you ever been knocked out, become unconscious, or lost your memory?		
11.	Has any family member or relative died of heart problems or of sudden death before age 50?		
12.	Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month?		
13.	Has a physician ever denied or restricted your participation in sports for any heart problems?		
14.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		
15.	Have you ever had a head injury or concussion?		
16.	Have you ever had a stinger, burner, or pinched nerve?		
17.	Have you ever had a seizure?		
18.	Do you have frequent or severe headaches?		
19.	Do you have sickle cell trait?		
20.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
21.	Do you cough, wheeze, or have trouble breathing during or after activity?		
22.	Do you have asthma?		
23.	Do you have seasonal allergies that require medical treatment?		
24.	Do you have diabetes? Use insulin?		
25.	Do you lose weight regularly to meet weight requirements for your sport?		
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)?		
27.	Have you ever had any problems with your eyes or vision? Wear glasses or contacts?		
28.	Have you ever been told you have a heart murmur?		
29.	Have you ever had a sprain, strain, or swelling after injury?		
30.	Have you broken or fractured any bones or dislocated any joints?		
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?		
33.	Do you have Marfan's Syndrome?		
34.	Are you easily fatigued?		

Head Elbow Hip Neck Foot
Forearm Thigh Back Wrist Knee
Chest Hand Shin/Calf Upper Arm
Shoulder Finger Ankle

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.

Sign Here

Signature of Student Athlete _____

Date Signed: _____ Signature of Parent/Guardian _____

Revised March 2019 (white copies)

Cecil County Public Schools
ATHLETICS PHYSICAL EXAMINATION FORM

BLOOD PRESSURE	_____

Patient's Name: _____ DOB: _____ Height: _____ Weight: _____

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

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/ Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

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: _____

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: _____

Revised March 2019 (white copies)

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: _____

HEALTH INSURANCE INFORMATION

MY SIGNATURE VERIFIES THAT MY SON/DAUGHTER IS COVERED BY EITHER PRIVATE HEALTH INSURANCE OR SCHOOL PURCHASED INSURANCE.

Insurance Company: _____ Policy Number: _____

If you have purchased School Student Insurance, please send verification of insurance and enter the policy number below.

K& K Insurance Policy Information: _____

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 changed or 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 a concussion information sheet for both parents/guardians and athletes to review **before** participation may occur. This information is also available on the CCPS website. The pages have the following logos on them.

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.

Student Athlete Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

CONSENT and RELEASE OF INFORMATION
FOR SPORTS CONCUSSION TESTING PROGRAM

For Student Athletes participating in
Field Hockey, Football, Soccer, Basketball, Wrestling, Cheerleading, Baseball, Softball and Lacrosse

I understand that pre-concussion baseline testing may be administered at my son/daughter's high school, and is a part of the procedure for guiding their return to sports participation after the injury.

Procedures

- There is no charge to the athlete for this pre-concussion baseline testing conducted at the school.
- The results of this pre-concussion testing will be reviewed and filed in a secure website by the Concussion Management Program hosted at Cecil County Public Schools.
- If my son or daughter sustains a concussion, a post-injury test may be necessary for comparison with the baseline test to help guide return to sports participation.
- The post-injury tests are administered at the school by the Athletic Trainers.
- I may choose to use the Concussion Management Program as the concussion specialist or I may elect to consult with my primary care physician or another concussion specialist outside of the school system to assist my son/daughter's recovery. Results of the pre-concussion testing can be made available in writing only on request.
- Cecil County Public Schools (CCPS) is not providing medical coverage or reimbursement for any testing, assessment, follow-up, or rehabilitation beyond the initial pre-concussion baseline screening test.

Limitations on Use of Information

- I understand that the concussion baseline testing is designed only for concussion management and not as an intelligence or IQ test and will not be used for educational planning or placement decisions.
- It is important to recognize that blows to the head can cause a variety of injuries other than concussions (e.g., neck injuries, more serious brain injuries). The sports concussion program is designed for concussions only. You must see your doctor as soon as possible to address any other medical concerns.

Storage, Use of Information, Persons Authorized Access, and Confidentiality

- All medical personnel will comply with all HIPAA procedures in regards to these records.

Acknowledgement and Consent

I have read this document completely and I understand the terms and conditions set forth above under Procedures, Limitation on Use of Information, and Storage, Use of Information, Persons Authorized Access, and Confidentiality. I understand that this testing program is not a mandatory requirement of sports participation but voluntary participation in this program is highly recommended by Cecil County Public Schools. I consent to the administration of the concussion testing of my child under this program and to the release of my child's testing information and related protected health information to the individuals specified in this form.

_____ **I CONSENT for Concussion Baseline Testing for my child as needed.**

_____ **I DECLINE Concussion Baseline Testing for my child.**

Printed Name of Student Athlete: _____

Printed Name of parent or guardian(s): _____

Parent/Guardian Signature: _____

Date: _____

CECIL COUNTY PUBLIC SCHOOLS
ATHLETIC EMERGENCY MEDICAL TREATMENT CARD (Rev. March 2016)

Athlete: _____ **DOB:** _____

Home Address: _____

_____

Parent/Guardian Contact Information (If multiple households, please include all information.)

Name: _____ **Relationship to student:** _____

Phone(s) Cell/Work/Home: _____

Name: _____ **Relationship to student:** _____

Phone(s) Cell/Work/Home: _____

Emergency name and phone if Parent/Guardian cannot be reached:

Name: _____ **Relationship to student:** _____

Phone(s) Cell/Work/Home: _____

Insurance/Doctor Information:

Doctor's Name/ Practice: _____

Dentist's Name/ Practice: _____

Health Insurance Company: _____ **Group/Policy #:** _____

Allergies (include allergies to bee stings): _____

_____

List of current medications: _____

_____

Date of Last Tetanus Shot: _____

List significant medical history below. Include specific medical conditions and treatments, surgery, fractures, etc. _____

_____

_____

Has student ever experienced a traumatic head injury (a blow to the head)? ☐ **Yes** ☐ **No**

If yes, when? Dates (month/year): _____

Has student ever received medical attention for a head injury? ☐ **Yes** ☐ **No**

If yes, when? Dates (month/year): _____

Was student ever diagnosed with a concussion? ☐ **Yes** ☐ **No**

If yes, when? please describe the circumstances: _____

_____

_____

Parent/Guardian Signature: _____ **Date:** _____

Student-Athlete Signature: _____ **Date:** _____