2018-2019
CCPS and MPSSAA
REQUIRED PAPERWORK
TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS

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CONTENTS AVAILABLE AT WWW.CARROLLK12.ORG – ATHLETICS - OR AT YOUR HIGH SCHOOL’S MAIN OFFICE
STUDENT ATHLETE INFORMATION FORM

2018-19 STARTING DATES
FALL SEASON – WEDNESDAY, AUGUST 8, 2018
WINTER SEASON – THURSDAY, NOVEMBER 15, 2018
SPRING SEASON – FRIDAY, MARCH 1, 2019

(This entire packet must be turned in to the head coach prior to or on the first day of try outs)

STUDENT-ATHLETE’S NAME: 

SPORT TRYING OUT FOR: 

STUDENT-ATHLETE’S GRADE IN SCHOOL: 

9th 10th 11th 12th (Circle One)

STUDENT-ATHLETE’S BIRTH DATE: 

MONTH DAY YEAR

YEARS PARTICIPATED IN THIS HIGH SCHOOL SPORT (NOT INCLUDING THIS YEAR) 

1 2 3 (Circle One)

<table>
<thead>
<tr>
<th>Year</th>
<th>High School(s) Attended</th>
<th>Grade</th>
<th>Sports Played</th>
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</table>
PRE-PARTICIPATION HEAD INJURY/CONCUSSION REPORTING FORM FOR EXTRACURRICULAR ACTIVITIES

This form should be completed by the student’s parent(s) or legal guardian(s). It must be submitted to the Athletic Director, or official designated by the school, prior to the start of each season a student plans to participate in an extracurricular athletic activity.

Student Information

Name of Athlete: ______________________________________    School:  ____________________________

Sport/Season: ________________________________________

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): ____________________________
If yes, please describe the circumstances:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Was student diagnosed with a concussion?          Yes ______ No ______
If yes, when? Dates (month/year): ____________________________
Duration of symptoms (such as headaches, difficulty concentrating, fatigue) for most recent concussion:
_____________________________________________________________________________________

~ ~ ~

PHYSICAL EXAMINATION FORM CHECK

*This form is to be completed for student-athletes who have already played or tried out for a sport.
Physiological Examinations are valid for 13 months.

I ____________________________, participated in
(list student-athlete’s name here)

________________________________________, during the FALL, WINTER or SPRING season.
(list sport here)
Do you have any history of juvenile arthritis or connective tissue disease?

Do any of your joints become painful, swollen, feel warm, or look red?

Do you have a bone, muscle, or joint injury that bothers you?

Do you regularly use a brace, orthotics, or other assistive device?

Have you ever had a stress fracture?

Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?

Have you ever had any broken or fractured bones or dislocated joints?

Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)

Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?

Does anyone in your family have a heart problem, pacemaker, or any other organ?

Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning, unexplained car accident, or sudden infant death syndrome?

Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning, MRSA skin infection?

Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning, unexplained car accident, or sudden infant death syndrome? (males), your spleen, or any other organ?

Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning, unexplained car accident, or sudden infant death syndrome? (females), your spleen, or any other organ?

Has any family member or relative died of heart problems?

Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)

Has a doctor ever told you that you have any heart problems? If so, check all that apply:

- High blood pressure
- A heart murmur
- High cholesterol
- A heart infection
- Kawasaki disease
- Other:

Does your heart ever race or skip beats (irregular beats) during exercise?

Have you ever been unable to move your arms or legs after being hit or falling?

Do you or someone in your family have sickle cell trait or disease?

Have you ever been unable to move your arms or legs after being hit or falling?

Have you ever been unable to move your arms or legs after being hit or falling?

Do you get more tired or short of breath more quickly than your friends?

Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?

Have you ever had a stress fracture?

Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)

Do you regularly use a brace, orthotics, or other assistive device?

Do you have a bone, muscle, or joint injury that bothers you?

Do any of your joints become painful, swollen, feel warm, or look red?

Do you have any history of juvenile arthritis or connective tissue disease?

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. [INITIAL]
CARROLL COUNTY PUBLIC SCHOOLS
PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name ___________________________________________ Date of Birth ____________________

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
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</thead>
<tbody>
<tr>
<td>Height</td>
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<tr>
<td>BP / (</td>
<td>Pulse</td>
<td>Vision R 20/</td>
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<tr>
<td>MEDICAL</td>
<td>NORMAL</td>
<td>ABNORMAL FINDINGS</td>
<td></td>
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<tr>
<td>Appearance</td>
<td></td>
<td></td>
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<tr>
<td>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</td>
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<tr>
<td>Eyes/ears/nose/throat</td>
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<tr>
<td>• Pupils equal</td>
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<td>• Hearing</td>
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<tr>
<td>Lymph nodes</td>
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<td>Heart a</td>
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<tr>
<td>• Murmurs (auscultation standing, supine, +/- Valsalva)</td>
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<tr>
<td>• Location of point of maximal impulse (PMI)</td>
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<tr>
<td>Pulses</td>
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<tr>
<td>• Simultaneous femoral and radial pulses</td>
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<tr>
<td>Lungs</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Genitourinary (males only)b</td>
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<tr>
<td>Skin</td>
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<tr>
<td>• HSV, lesions suggestive of MRSA, tinea corporis</td>
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<tr>
<td>Neurologic c</td>
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<tr>
<td>MUSCULOSKELETAL</td>
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<tr>
<td>Neck</td>
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<tr>
<td>Back</td>
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<tr>
<td>Shoulder/arm</td>
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<tr>
<td>Elbow/forearm</td>
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<tr>
<td>Wrist/hand/fingers</td>
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<tr>
<td>Hip/thigh</td>
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<tr>
<td>Knee</td>
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<td>Leg/ankle</td>
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<td>Foot/toes</td>
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<tr>
<td>Functional</td>
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<tr>
<td>• Duck-walk, single leg hop</td>
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</table>

a Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
b Consider GU exam if in private setting. Having third party present is recommended.
c Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____________________________________________________________

☐ Not cleared
☐ Pending further evaluation
☐ For any sports
☐ For certain sports ____________________________________________________________

Reason ____________________________________________________________

Recommendations ____________________________________________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ___________________________ Date of Exam ________________

Address ___________________________________________ Phone ________________

Signature of physician ___________________________________________ MD or DO

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HE0503 9-2681/041
FOR FOOTBALL ONLY

125 North Court Street – Westminster, MD  21157

Parental Permission to Participate in Interscholastic Football

TO:   Athletic Director of _______________________________ High School

I hereby give my child, ________________________________, permission to participate in the

interscholastic football program at _________________________________ High School for

the 2018-2019 season. I further give permission to the Board of Education to transport my

child to games by appropriate means.

Exposure to Injury

I understand that, in the engagement of contact sports such as interscholastic football, despite the

best efforts of the staff in training the students and selection of modern equipment, it is possible to

suffer injury to participants in such sports. I further understand that such injuries can be severe. I

have certified in the separate Football Medical Insurance Certification Form that I have some form

of medical insurance coverage (either personal or the football insurance program offered by CCPS)

to provide some financial protection against the medical costs which could result from injuries

which are sustained by my child.

Equipment Responsibility

I understand that it is the responsibility of my child to maintain and return all equipment and

uniforms issued to him. I understand that I will be financially responsible for any equipment or

uniforms which are lost, stolen, or misplaced while my child is responsible for them. The price of

replacing these items will be the actual cost to the school for purchasing new replacement items.

Until any charges for lost equipment have been paid, my child will not be eligible to participate on

any other high school athletic team.

I have read, understand and agree to these statements and responsibilities.

Parent’s Signature __________________________________ Date: ______________

Student’s Signature ________________________________ Date: ______________

FOR FOOTBALL ONLY
AUTHORIZATION FOR PARTICIPATION IN INTERSCHOLASTIC/COROLLARY ATHLETICS

As parents or legal guardians of ____________________________

(Name of Student)

We hereby authorize and consent to our child’s participation in interscholastic/corollary athletics and sports. We understand the sport in which our child will be participating is potentially dangerous, and that physical injuries may occur to our child requiring emergency medical care and treatment. We recognize that, even with proper training and equipment, there is always a risk of serious accidental injury or death inherent in interscholastic/corollary athletics and sports.

In consideration of the acceptance of our child by the Carroll County Public Schools in its athletic program, we agree to release and hold harmless the Board of Education of Carroll County, its members, the Superintendent of Schools, the Principal, all coaches, and assistant coaches, and any and all other agents, servants, and/or employees and agree to indemnify each of them, from any and all claims, costs, suits, actions, judgment, and expenses, arising from our child’s participation in interscholastic/corollary athletics and sports.

We hereby give our consent and authorize the Board of Education of Carroll County and its agents, servants, and/or employees to consent on our behalf and on the behalf of our child, to emergency medical care and treatment in the event we are unable to be notified by reasonable attempt of the need for such emergency medical care and treatment.

We understand and agree that we will be responsible for all medical bills and costs that may be incurred as a result of medical and treatment of our child, and agree to provide proof of insurance coverage of our child against accidents and injuries in school sponsored games, and practice sessions, and during travel to and from athletic contests.

Students who have made a decision to take part in the athletic program will be required to practice and participate in scheduled contests after school and possibly on non-school days. Supervision at practice, games, and travel will be provided by the school.

In addition, it is recognized that all students must comply with eligibility regulations that govern athletics in Carroll County Public Schools as approved by the County Board of Education and the State Department of Education.

It is the responsibility of the parent or guardian, and not that of school officials, to determine the amount of insurance protection necessary to adequately insure against serious accidental injury. It is also the responsibility of the parent or guardian to make sure that all insurance premiums are timely paid, that there is no lapse of insurance coverage, and that their child is insured from the first day of practice to the last day of post-season competition. The Board of Education of Carroll County is not an insurer, and, under no circumstances, will the Board of Education of Carroll County, its members, agents, employees, or insurers be held liable for any injury or death arising out of a child’s participation in interscholastic/corollary athletics or sports, or as a result of inadequate insurance coverage.

I also declare and affirm that my child resides within the attendance area of ____________________________ High School, or is attending ____________________________ with special permission of the office of Student Services of Carroll County Public Schools. If a student is attending a high school without the benefit of residing within the school’s attendance area and/or without special permission of the Office of Pupil Services the student in question is subject to disciplinary action which could result in loss of athletic eligibility for a period of time, ineligibility in a specified sport for the forthcoming year or penalties as may seem justified in the particular case. It is also possible for the athlete’s team and school to be penalized.

By evidence of the signatures below, you are testifying that you:
1. Have read the Guide for Student Athletes and Parents
2. Understand the residency requirements (above) and the eligibility requirements
3. Received and read the Concussion Information Sheet and understand the school system’s concussion policy
4. Received, read and understand the Sudden Cardiac Arrest Awareness Form
5. Have read the provisions of the Authorization for Participation in Interscholastic/Corollary Athletics Form
6. Give permission for participation and assume risk for injury that may occur
7. Acknowledge valid insurability by school or private insurance carrier

Numbers 1 through 4 above are available at www.carrollk12.org – Athletics

Please check appropriate space:

I have:       Insurance

_________________School Time Student Accident       _____________No Insurance
_________________24 Hour Student Accident           _____________Other Insurance-Family
_________________Voluntary Interscholastic Football*  sponsor

_________________Voluntary Interscholastic Football*

Name of Insurance Company

_________________Name of Insurance Company

_________________(Student’s Signature)           _____________(Date)

_________________(Parent/Legal Guardian’s Signature)  _____________(Date)

FAILURE TO COMPLETE, SIGN AND RETURN TO YOUR CHILD’S COACH WILL RESULT IN HIS/HER EXCLUSION FROM PARTICIPATION IN THE INTERSCHOLASTIC/COROLLARY ATHLETIC PROGRAM OF CARROLL COUNTY PUBLIC SCHOOLS.

* Football coverage required if parents DO NOT maintain other health/accident insurance.
EMERGENCY MEDICAL AND FIELD TRIP FORM

Student ___________________________ DOB ____________ Phone______________

Address ___________________________________________________________________________________

Parent/Guardian ___________________________ Phone: Home ____________ Work ____________

Other Contact _____________________________ Phone: Home ____________ Work ____________

Doctor _________________________________ Phone _______________________

Insurance Company ______________________

Medical Information and/or Restrictions (allergies to insect bites, hypoglycemia, etc.):
________________________________________________________________________________________
________________________________________________________________________________________

I consent to and authorize the Board of Education personnel or their designee to contact me by phone, e-mail or
text should my child have an athletic related medical emergency.
Cell Phone: ____________________ e-Mail: ____________________

__________________________________________  ______________________________

Parent/Guardian Signature                Date

I consent to and authorize the Board of Education personnel or their designee to take whatever reasonable steps
he/she deems necessary in order to provide emergency medical care for my child. I further agree to permit my
child to be transported to a medical facility by ambulance or other commercial vehicle.

__________________________________________  ______________________________

Parent/Guardian Signature                Date

MEDICAL STATUS CHANGE

Has the medical status of your child changed since his/her last physical examination?
Yes _______    No _______

If yes, your child’s physician MUST verify and release that your child is able to fully participate in the
designated sport in order to participate. Verification and release must take place from your child’s
medical physician prior to participation.

If no, please indicate not applicable.

__________________________________________  ______________________________

Parent/Guardian Signature                Date

CONSENT FORM

I/We hereby give my/our consent and authorize the disclosure of medical information between the
coaching staff, school medical staff, and the school administration while participating in interscholastic
athletics and sports.

__________________________________________  ______________________________

Parent/Guardian Signature                Date

Revised 7/1/15
EMERGENCY MEDICAL AND FIELD TRIP FORM

Student ___________________________ DOB ___________ Phone ___________

Address ___________________________________________________________________________________

Parent/Guardian ___________________________ Phone: Home ___________ Work ___________

Other Contact _____________________________ Phone: Home ___________ Work ___________

Doctor ___________________________ Phone ___________________________________

Insurance Company _____________________________

Medical Information and/or Restrictions (allergies to insect bites, hypoglycemia, etc.):
__________________________________________________________________________________________
__________________________________________________________________________________________

I consent to and authorize the Board of Education personnel or their designee to contact me by phone, e-mail or
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Cell Phone: ____________________ e-Mail: ____________________

__________________________________________  ______________________________
Parent/Guardian Signature                Date

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Revised 7/1/15