

**2016-2017
CCPS and MPSSAA
REQUIRED PAPERWORK
TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS**

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STUDENT ATHLETE INFORMATION FORM

2016-17 STARTING DATES

FALL SEASON – WEDNESDAY, AUGUST 10, 2016

WINTER SEASON – TUESDAY, NOVEMBER 15, 2016

SPRING SEASON – WEDNESDAY, MARCH 1, 2017

**(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)

Year	High School(s) Attended	Grade	Sports Played

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.**

Physical 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)

HISTORY FORM

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

[illegible]

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CARROLL COUNTY PUBLIC SCHOOLS

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

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

- 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



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 2016-2017 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: School Insurance

_____ School Time Student Accident
_____ 24 Hour Student Accident
_____ Voluntary Interscholastic Football*

_____ No Insurance
_____ Other Insurance-Family
_____ sponsored

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.

* Varsity Football coverage required if parents **DO NOT** maintain other health/accident insurance.

Note: JV football players who become varsity football players **MUST** have Voluntary Interscholastic Football insurance or family sponsored Health Care 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

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