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			YES	NO
1.	Have you ever had a medical illness or injury since your last check up or sports physical?			20.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
2.	Are you currently taking a prescription or non-prescription (over-the counter) medications?			21.	Do you cough, wheeze, or have trouble breathing during or after activity?		
3.	Have you ever been hospitalized overnight?			22.	Do you have asthma?		
4.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?			23.	Do you have seasonal allergies that require medical treatment?		
5.	Have you ever passed out or been dizzy during or after exercise?			24.	Do you have diabetes? Use insulin?		
6.	Have you ever had chest pain during or after exercise?			25.	Do you lose weight regularly to meet weight requirements for your sport?		
7.	Have you ever become ill from exercising in the heat?			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)?		
8.	Have you ever had racing of your heart or skipped heartbeats?						
9.	Have you had high blood pressure or high cholesterol?			27.	Have you ever had any problems with your eyes or vision? Wear glasses or contacts?		
10.	Have you ever been knocked out, become unconscious, or lost your memory?			28.	Have you ever been told you have a heart murmur?		
11.	Has any family member or relative died of heart problems or of sudden death before age 50?			29.	Have you ever had a sprain, strain, or swelling after injury?		
12.	Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month?			30.	Have you broken or fractured any bones or dislocated any joints?		
13.	Has a physician ever denied or restricted your participation in sports for any heart problems?			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:		
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?				Head Elbow Hip Neck Foot Forearm Thigh Back Wrist Knee Chest Hand Shin/Calf Upper Arm Shoulder Finger Ankle		
16.	Have you ever had a stinger, burner, or pinched nerve?						
17.	Have you ever had a seizure?			32.	Do you have any communicable diseases?		
18.	Do you have frequent or severe headaches?			33.	Do you have Marfan's Syndrome?		
19.	Do you have sickle cell trait?			34.	Are you easily fatigued?		

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 _____

Revised July 2020 (white copies)

Cecil County Public Schools
ATHLETICS PHYSICAL EXAMINATION FORM

BLOOD _____

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			
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: _____

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: _____

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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: _____

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