2022-2023
CCPS and MPSSAA
REQUIRED ATHLETICS FORMS
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

2022-23 STARTING DATES
FALL SEASON – WEDNESDAY, AUGUST 10, 2022
WINTER SEASON – TUESDAY, NOVEMBER 15, 2022
SPRING SEASON – WEDNESDAY, MARCH 1, 2023

(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>
</tr>
</thead>
<tbody>
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</table>
CARROLL COUNTY PUBLIC SCHOOLS

All of these forms must be completed and signed/dated

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.
Name: ___________________________ Date of birth: ___________________________
Date of examination: ___________________________ Sport(s): ___________________________

Have you had COVID-19? (check one): □ Y □ N
Have you been immunized for COVID-19? (check one): □ Y □ N
If yes, have you had: □ One shot □ Two shots
List past and current medical conditions: _______________________________________________________

Have you ever had surgery? If yes, list all past surgical procedures: _______________________________________

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional): _______________________________________________________

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects): _______________________________________________________

Patient Health Questionnaire Version 4 (PHQ-4)
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Not at all</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS
(Explain “Yes” answers at the end of this form. Circle questions if you don’t know the answer.)

1. Do you have any concerns that you would like to discuss with your provider?

2. Has a provider ever denied or restricted your participation in sports for any reason?

3. Do you have any ongoing medical issues or recent illness?

HEART HEALTH QUESTIONS ABOUT YOU

4. Have you ever passed out or nearly passed out during or after exercise?

5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?

6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?

7. Has a doctor ever told you that you have any heart problems?

8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.

9. Do you get light-headed or feel shorter of breath than your friends during exercise?

10. Have you ever had a seizure?

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?

12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?

13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?
I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: 

Signature of parent or guardian: 

Date: 

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _________________________________________________________________

Date of birth: ____________________________

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION

Height: ______________________________ Weight: ____________________________

<table>
<thead>
<tr>
<th>BP:</th>
<th>Pulse:</th>
<th>Vision: R 20/</th>
<th>L 20/</th>
<th>Corrected:</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ ( / )</td>
<td></td>
<td></td>
<td></td>
<td>□ Y □ N</td>
</tr>
</tbody>
</table>

COVID-19 VACCINE

Previously received COVID-19 vaccine: □ Y □ N

Administered COVID-19 vaccine at this visit: □ Y □ N

If yes: □ First dose □ Second dose

MEDICAL

NORMAL ABNORMAL FINDINGS

Appearance

• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)

Eyes, ears, nose, and throat

• Pupils equal
• Hearing

Lymph nodes

Heart*

• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)

Lungs

Abdomen

Skin

• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis

Neurological

MUSCULOSKELETAL

NORMAL ABNORMAL FINDINGS

Neck

Back

Shoulder and arm

Elbow and forearm

Wrist, hand, and fingers

Hip and thigh

Knee

Leg and ankle

Foot and toes

Functional

• Double-leg squat test, single-leg squat test, and box drop or step drop test

* Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): __________________________ Date: __________________________

Address: __________________________ Phone: __________________________

Signature of health care professional: __________________________, MD, DO, NP, or PA


This form should be placed into the athlete’s medical file and should not be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.
PREPARTICIATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: ____________________________ Date of birth: ____________________________

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of ____________________________

☐ Medically eligible for certain sports

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: ____________________________

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): ____________________________ Date: ____________________________

Address: ____________________________ Phone: ____________________________

Signature of health care professional: ____________________________

MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: ____________________________

Medications: ____________________________

Other information: ____________________________

Emergency contacts: ____________________________

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.
**PREPARTICIPATION PHYSICAL EVALUATION**

**ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY**

Name: ___________________________ Date of birth: ___________________________

1. Type of disability: ___________________________

2. Date of disability: ___________________________

3. Classification (if available): ___________________________

4. Cause of disability (birth, disease, injury, or other): ___________________________

5. List the sports you are playing:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
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</table>

6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities? Yes No

7. Do you use any special brace or assistive device for sports? Yes No

8. Do you have any rashes, pressure sores, or other skin problems? Yes No

9. Do you have a hearing loss? Do you use a hearing aid? Yes No

10. Do you have a visual impairment? Yes No

11. Do you use any special devices for bowel or bladder function? Yes No

12. Do you have burning or discomfort when urinating? Yes No

13. Have you had autonomic dysreflexia? Yes No

14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness? Yes No

15. Do you have muscle spasticity? Yes No

16. Do you have frequent seizures that cannot be controlled by medication? Yes No

**Explain “Yes” answers here.**

Please indicate whether you have ever had any of the following conditions:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiographic (x-ray) evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
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<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
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<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
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<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
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<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
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<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td></td>
<td></td>
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<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
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<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
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</tbody>
</table>

**Explain “Yes” answers here.**

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: ___________________________

Signature of parent or guardian: ___________________________

Date: ___________________________

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 2022-2023 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
_________________ 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.

* 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