2022-2023
CCPS and MPSSAA
REQUIRED PAPERWORK FOR ATHLETES WHO HAVE PLAYED A SEASON IN CURRENT SCHOOL YEAR

TABLE OF CONTENTS

1. STUDENT ATHLETE INFORMATION FORM
2. PRE-PARTICIPATION/PHYSICAL EXAMINATION FORM CHECK
3. EMERGENCY MEDICAL & FIELD TRIP FORM/MEDICAL STATUS CHANGE (1)

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

(THESE 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: (Circle One)
- 9th
- 10th
- 11th
- 12th

STUDENT-ATHLETE’S BIRTH DATE: _______________________

MONTH    DAY    YEAR

YEARS PARTICIPATED IN THIS HIGH SCHOOL SPORT (NOT INCLUDING THIS YEAR) (Circle One)
- 1
- 2
- 3

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<th>Year</th>
<th>High School(s) Attended</th>
<th>Grade</th>
<th>Sports Played</th>
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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)
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