

# Cecil County Public Schools

# Interscholastic Athletics

This packet is used for ALL MIDDLE & HIGH SCHOOL sports.

Name (Last): _____	(First): _____	
Grade: _____	School: _____	Date Completed: _____
Sport(s): _____		

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- to be completed by a physician- <b>Dated on or after June 1, 2026</b>	
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### Separate Items:

Emergency Card (inserted in package or handed to you for completion by parent)----- Insert

**Keep this packet together and return it all to the coach when complete.**

Be sure you have **SIGNED** next to any place in the booklet that has this symbol.

Parent's signature must be on **ALL** forms prior to participation.

If you have any questions, please contact your child's school.



**RETURN THIS**  
**ATHLETIC FORMS PACKET**  
**TO YOUR SCHOOL**



# CECIL COUNTY PUBLIC SCHOOLS (CCPS)

## Checklist for Sports Registration

\_\_\_\_\_ 1. Please make sure to read all information in the **Guidelines Packet for Parents and Students** along with the information your school/coach provides about eligibility, expectations, tryouts, practice and game schedules, and transportation.

\_\_\_\_\_ 2. **Medical History form – page 2**  
**This section should be completed by the student and parent/guardian.**

Please fill out the Student Athlete Health History form, take it to your Pre-participation Physical Exam appointment and review with the Healthcare Professional.

Make sure to clarify/explain any questions that you have answered “YES”.  
Please keep a copy to turn into the school.

\_\_\_\_\_ 3. Pre-participation Physical Exam (PPE) – page 3  
**Complete the top section of patient’s name, DOB, and school.**

**The rest** will be completed by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Certified Registered Nurse Practitioner (CRNP) or Physician Assistant – Certified (PA-C) only.

### **Before leaving the appointment, please make sure the following have been completed:**

- The Healthcare provider signed, dated, and stamped the PPE.
- The Healthcare provider has checked off the appropriate participation in athletics box.
- You have both the Health History form and Pre-participation, Physical Exam (PPE) form. (you will need to provide both forms to the school during sports registration).

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: M / F Age: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_



# Cecil County Public Schools Interscholastic Athletics

## MEDICAL HISTORY FORM

**(STUDENT/PARENT'S SECTION)** (Grades 6-12)

The parent/guardian and student should complete this section together.

GENERAL MEDICAL HISTORY	YES	NO	Explain YES answers at the end.	YES	NO
Do you have any concerns you want to discuss with your provider?			Do you have sickle cell traits or disease?		
Has a provider ever denied or restricted your participation in sports for any reason?			Does someone in your family have sickle cell trait or disease?		
Do you have any ongoing medical conditions? If so, please identify:  <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections. Other: _____			Have you had any other blood disorders?		
			Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?		
Are you taking any medications or supplements daily?			Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?		
Do you have allergies to any medications?			Have you had or do you have any problems with your eyes or vision?		
Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			Do you wear glasses or contacts?		
Have you ever spent the night in the hospital?			Have you had or do you have any problems with your eyes or vision?		
Have you ever had surgery?			Do you worry about your weight?		
Have you had mononucleosis (mono) within the last month?			Have you ever been diagnosed with an eating disorder?		
Are you missing a kidney, eye, testicle, spleen or other internal organ?			Are you on a special diet or do you avoid certain types of foods or food groups?		
Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			Allergies to food or stinging insects?		
Have you ever become ill while exercising in the heat?			Have you ever had a COVID-19 diagnosis?		
When exercising in the heat, do you have severe muscle cramps?			What is the date of your last Tdap or Td (tetanus) immunization? (circle type) <b>Date:</b> _____		
Do you have headaches from exercise			Do you cough, wheeze, or have difficulty breathing during or after exercise?		
Have you ever had numbness, tingling or weakness in your arms or legs or been unable to move your arms or legs AFTER being hit or falling?			Do you have asthma or use asthma medicine (inhaler, nebulizer)?		

HEART HEALTH QUESTIONS ABOUT YOU	YES	NO	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	YES	NO
Have you ever passed out or nearly passed out DURING or AFTER exercise?			Does anyone in your family have a heart problem?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning or unexplained car crash)?		
Does your heart race, flutter in your chest or skip beats (irregular beats) during exercise?			Has anyone in your family had a pacemaker or an implanted defibrillator before age 50?		
Has a doctor ever ordered a test for your heart? For example, electrocardiography or echocardiography.			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)?		
Has a doctor ever told you that you have any heart problems, including: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other					
Do you get light-headed or feel shorter of breath than your friends during exercise?					
Have you ever had a seizure?					


BONE AND JOINT QUESTIONS	YES	NO	FEMALES ONLY	YES	NO
Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss practice or a game?			Have you ever had a menstrual period? If so, list date of your first menstrual period. _____		
Do you currently have a bone, muscle, or joint injury that bothers you?			Number of periods in the last 12 months:		
			When was your most recent menstrual period?		

<p>List medications and nutritional supplements you are currently taking here:</p>	<p>EXPLAIN "YES" ANSWERS HERE:.</p>
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**By signing below,**

- I understand and agree that student-athletes are not to use tobacco, alcohol, or other drugs at any time. Any substantiated reported use of alcohol, tobacco, or other drugs in school will be handled in accordance with 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, of 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 for those activities crossed out by the examining physician on the PPE 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 _____

**YOUR SCHOOL**  
\_\_\_\_\_

**Cecil County Public Schools  
ATHLETICS PHYSICAL EXAMINATION FORM**

**BLOOD  
PRESSURE**  
\_\_\_\_\_

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Height		Weight		Sex Assigned at Birth		
RR	Resting pulse	Vision R 20/	L 20/	Corrected	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>MEDICAL</b>						
				<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	
Appearance (Marfan stigmata: kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse, and aortic insufficiency)						
Eyes/ears/nose/throat (Pupils equal, hearing)						
Neck - Lymph nodes, thyroid enlargement						
Heart (Murmurs: auscultation standing, supine, +/- Valsalva)						
Pulses (radial, femoral, pedal)						
Lungs						
Abdomen						
Skin (Herpes simplex virus, lesions suggestive of MRSA or tinea corporis)						
Neurologic (cranial nerve and gait)						
<b>MUSCULOSKELETAL</b>				<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	
Neck						
Back						
Shoulder/arm						
Elbow/forearm						
Wrist/hand/fingers						
Hip/thigh						
Knee						
Leg/ankle						
Foot/toes						
Functional (i.e. Double leg squat, single leg squat, box drop, or step drop test)						

**(completed by doctor)  
MENTALHEALTH SCREENING – New for 26-27**

**Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)**

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

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

**ATHLETICS PHYSICAL EXAMINATION FORM (PAGE 2)  
DOCTOR ONLY**

**CLEARANCE:** I have, on this date, personally examined this pupil and reviewed the history and other data recorded on this form. I, as the **Healthcare Professional, have reviewed the Mental Health Screening Questions with the athlete.**

**CROSS OUT** any sport this student is **NOT PHYSICALLY ABLE** to compete in and list the reason(s) below.

Baseball	Basketball	Bocce	Bowling	Cheerleading	Cross Country
Field Hockey		Football	Golf	Lacrosse	Soccer Softball
Swimming		Tennis	Track & Field	Volleyball	Wrestling
OTHER:	Marching Band	School of Tech Trade (If your trade requires additional information, you will need to see a private physician.)			

**NOT CLEARED Reason/ Recommendations:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Medical History and Mental Health Screening.**

DOCTOR'S SIGNATURE: \_\_\_\_\_ (MD, DO, NP or PA) + **DATE\*\*:** \_\_\_\_\_

EXAMINER'S NAME **(PRINT):** \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_


**Physician Office Stamp:**

+Only signature of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted.

**TO BE SIGNED BY THE 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 FOR HIGH SCHOOL ATHLETES

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 HIGH SCHOOL 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: _____	

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## HEALTH INSURANCE

**I KNOW THAT MY CHILD MUST BE COVERED BY HEALTH INSURANCE TO PARTICIPATE IN ANY CCPS ATHLETIC PROGRAM. MY SIGNATURE VERIFIES THAT MY SON/DAUGHTER IS COVERED BY EITHER PRIVATE HEALTH INSURANCE OR SCHOOL-PURCHASED INSURANCE.**

**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 terminated.**

Parent/Guardian	Signature: _____	
	Date: _____	

# 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 concussion information sheets for both parents/guardians and athletes to review **before** participation may occur. This information is also available on the CCPS website.

**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

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## 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: _____

