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): ____

Packet Contents: Page

Checklist for Sports Registration-- **1**

Medical History Form (to be completed by parent and student **BEFORE** physical and given to physician) **-2-3**

Athletic Preparticipation Physical Examination Form (PPE) completed by doctor ----------------------------------- **4**

- to be completed by a physician- **Dated on or after June 1, 2026**
- Parents must sign page 4 **AFTER** the doctor completes the physical exam

Parent's Permission Signature Form --- **5**

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

REVISED FOR 2026-27 SCHOOL YEAR (white copies)

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 2-3
This section should be completed by the student and parent/guardian.

Please fill out the Student Athlete Heath 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 4
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.

_______ 4. Parent's Permission Signature Form – page 5

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: □ Asthma □Anemia □Diabetes □ 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 or do you have any problems with your eyes or vision?		
Do you have allergies to any medications?			Do you wear glasses or contacts?		
Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			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?		
Have you ever spent the night in the hospital?			Do you worry about your weight?		
Have you ever had surgery?					
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) **Date:**		
Do you have headaches from exercise			Do you cough, wheeze, or have difficulty breathing during or after exercise?		

BONE AND JOINT QUESTIONS	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?		
Do you currently have a bone, muscle, or joint injury that bothers you?		

FEMALES ONLY	YES	NO
Have you ever had a menstrual period? If so, list date of your first menstrual period. ____________		
Number of periods in the last 12 months:		
When was your most recent menstrual period? **Date:**		

MEDICAL HISTORY FORM (STUDENT/PARENT'S SECTION) CONTINUED

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: □ High blood pressure □ A heart murmur □ High cholesterol □ A heart infection □ Kawasaki Disease □ Other					
Do you get light-headed or feel shorter of breath than your friends during exercise?			**EXPLAIN "YES" ANSWERS HERE:**		
Have you ever had a seizure?					

List medications and nutritional supplements you are currently taking here:

PHQ-4 – New for 26-27

If you prefer not to answer these questions, please CHECK HERE. ☐

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

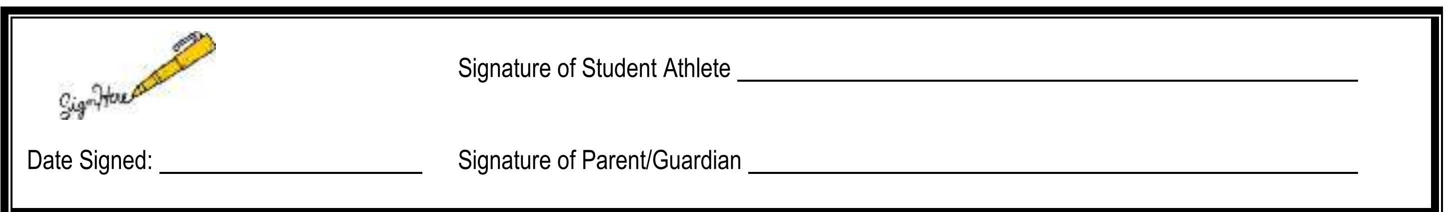
	Not at all	*Several days*	*Over half the days*	*Nearly every day*
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

☐ **Please enter total score in box**

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 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.

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
PHYSICIAN SECTION

BLOOD PRESSURE	_______

Patient's Name: ______________________________ DOB: ____________________

Height		Weight		Sex Assigned at Birth	
RR	Resting pulse	Vision R 20/	L 20/	Corrected	□ Yes □ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
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)		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
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)		

☐ **PHQ4 Review: I have reviewed the screening questions and provided intervention or referral if indicated.**

☐ **CLEARANCE: I have, on this date, personally examined this pupil and reviewed the history and other data recorded on this form.**
CROSS OUT any sport this student is NOT PHYSICALLY ABLE to compete in and list the reason(s) below.
Baseball, Basketball, Bocce, Bowling, Cheer, Cross Country, Field Hockey, Football, Golf, Lacrosse, Soccer, Softball, Swim, Tennis, Track & Field, Volleyball, Wrestling, OTHER: Marching Band OR School of Tech Trade

☐ **NOT CLEARED Reason/ Recommendations:** ______________________________

PHYSICIAN OFFICE USE
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.

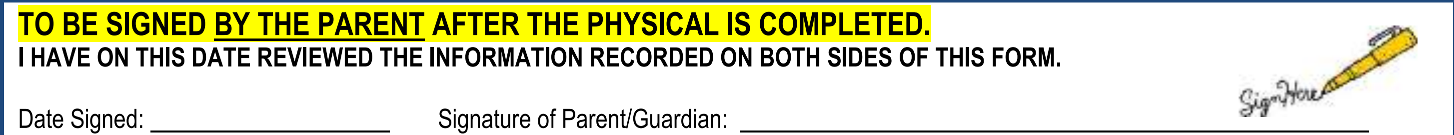
PHYSICIAN'S SIGNATURE: ______________________(MD, DO, NP or PA) + **DATE**:** ____________

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: ______________________

Student-Athlete Name & School: ____

CONSENT FOR ATHLETIC TRAINING SERVICES

I hereby grant permission for the **Certified Athletic Trainer (ATC)** to provide medical care to my child, including:

- **Treatment:** Emergency care, injury evaluation, and treatment of sport-related health issues during high school practices, contests, and in the athletic training room.
- **Equipment:** Provision of medical supplies (e.g., crutches, braces, wraps, etc.) as required for injury prevention or recovery.
- **Communication:** Sharing my child's "return to play" status with coaches and coordinating medical information with other healthcare providers (physicians, specialists, etc.) as necessary.

Duration: This consent remains valid for the current school year unless revoked by me in writing.

Parent/Guardian Signature: _______________________________________ **Date:** __________

INSURANCE VERIFICATION & LIABILITY WAIVER

Insurance Requirement: I certify that my child is covered by private or school-purchased health insurance, which is required for participation in CCPS athletics. I agree to notify the school in writing immediately if this coverage is terminated.

Waiver of Liability: In the event of an accidental injury sustained during the Interscholastic Athletic Program, I agree to hold the Board of Education, the school, and its staff harmless from any liability.

Parent/Guardian Signature: _______________________________________ **Date:** ____________

CONCUSSION & SUDDEN CARDIAC ARREST ACKNOWLEDGEMENT

State law requires that parents and athletes be informed of the risks associated with concussions and Sudden Cardiac Arrest (SCA). By signing below, I acknowledge that I have received and reviewed the CCPS Information Sheets regarding:

- Concussions: Definitions, signs/symptoms, prevention, and the requirement to "sit out" and seek medical attention following a suspected injury.
- Sudden Cardiac Arrest: Description, warning signs, and removal/return-to-play protocols.

Parent/Guardian Signature: __________________________________ **Date:** ____________

PERMISSION TO PARTICIPATE

I have read all statements in this registration packet, including the Concussion, Sudden Cardiac Arrest, and school-specific expectation sheets. I hereby give my written consent for my child to participate in the CCPS Interscholastic Athletic Program.

Student-Athlete Signature: __________________________________ **Date:** ____________

Parent/Guardian Signature: __________________________________ **Date:** ____________