

2026-2027
CCPS and MPSSAA
REQUIRED ATHLETICS FORMS
TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS

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STATUS CHANGE

STUDENT ATHLETE INFORMATION FORM

2026-27 STARTING DATES

FALL SEASON – AUGUST 12, 2026

WINTER SEASON – NOVEMBER 14, 2026

SPRING SEASON – MARCH 1, 2027

(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)

Year	High School(s) Attended	Grade	Sports Played



MARYLAND PUBLIC SECONDARY SCHOOL ATHLETIC ASSOCIATION (MPSSAA)
Recommended Preparticipation Physical Form
MPSSAA Medical Advisory Committee

Student Athlete and Parent/Guardian Check list for Sports Registration

- _____ 1. Please make sure to read all information that your school provides about Eligibility, Expectations, Tryouts, Practice & Game Schedules, Transportation (to and from games), Login to the School System Registration website.
- _____ 2. Page 2: Health History form. This is filled out by the student athlete & parent/guardian. Please fill out the Student Athlete Health History form, take it to the Pre-participation Physical Exam (PPE) 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. Page 3: Pre-participation Physical Exam (PPE). This 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.
Pre-participation Physical may not be completed/signed by a parent/guardian even if they are a licensed healthcare professional.
 - 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)
- _____ 4. Page 4: Emergency Information Form (to be completed and signed by parent/guardian). This information will be shared with the coach(es) in case of an emergency at practice/game.
- _____ 5. Students who require medication at school (including during school team practices or games) must have a doctor's order on file with the school's nurse for each medicine. Please visit this link and take this form to your Healthcare provider for school medication administration authorization. (This needs to be completed each year) [School Medication Administration Authorization Form \(marylandpublicschools.org\)](http://marylandpublicschools.org/School-Medication-Administration-Authorization-Form)

The information provided on the Health History and Pre-Participation Physical is considered confidential medical records, it is established and maintained for every student. The confidentiality of a student's medical records information is protected under the federal Family Education Rights and Privacy Act (FERPA), Maryland state law and/or the local school system policy, as applicable.

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.

Completion of the Preparticipation Physical is a requirement for student-athlete participation in interscholastic athletics. Falsifying information, forging signatures, or misrepresentation of a student's physical fitness compromises the health and safety of the student and may lead to penalties assessed by the local educational agency, including potential determination of ineligibility.

PART II- MEDICAL HISTORY (Explain "YES" answers below) Name: _____ **Grade:** _____

This form must be completed and signed, prior to the physical examination, for review by examining practitioner.

Explain "YES" answers below with number of the question. Circle questions you don't know the answers to.

GENERAL MEDICAL HISTORY		YES	NO	MEDICAL QUESTIONS CONTINUED		YES	NO
1. Do you have any concerns you want to discuss with your provider?				24. Have you had mononucleosis (mono) within the last month?			
2. Has a provider ever denied or restricted your participation in sports for any reason?				25. Are you missing a kidney, eye, testicle, spleen or other internal organ?			
3. Do you have any ongoing medical conditions? If so, please identify: Asthma Anemia Diabetes Infections. Other: _____				26. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			
4. Are you taking any medications or supplements daily?				27. Have you ever become ill while exercising in the heat?			
5. Do you have allergies to any medications?				28. When exercising in the heat, do you have severe muscle cramps?			
6. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?				29. Do you have headaches from exercise?			
7. Have you ever spent the night in the hospital? If yes, why? _____				30. 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?			
8. Have you ever had surgery?				31. Do you have sickle cell trait or disease? Does someone in your family have sickle cell trait or disease?			
HEART HEALTH QUESTIONS ABOUT YOU				32. Have you had any other blood disorders?			
9. Have you ever passed out or nearly passed out DURING or AFTER exercise?				33. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?			
10. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				34. Have you had, or do you have any problems with your eyes or vision?			
11. Does your heart race, flutter in your chest or skip beats (irregular beats) during exercise?				35. Do you wear glasses or contacts?			
12. Has a doctor ever ordered a test for your heart? For example, electrocardiography or echocardiography.				36. Do you wear protective eyewear like goggles or a face shield?			
13. Has a doctor ever told you that you have any heart problems, including: High blood pressure A heartmurmur High cholesterol A heart infection Kawasaki Disease Other _____				37. Do you worry about your weight?			
				38. Have you ever been diagnosed with an eating disorder?			
				39. Are you on a special diet or do you avoid certain types of foods or food groups?			
				40. Allergies to food or stinging insects?			
				41. Have you ever had a COVID-19 diagnosis? Date: _____			
				42. What is the date of your last Tdap or Td (tetanus) immunization? (circle type) Date: _____			
14. Do you get light-headed or feel shorter of breath than your friends during exercise?				FEMALES ONLY			
15. Have you ever had a seizure?				45. Have you ever had a menstrual period?	YES	NO	
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY				46. Age when you had your first menstrual period: _____			
16. Does anyone in your family have a heart problem?				47. Number of periods in the last 12 months: _____			
17. 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)?				48. When was your most recent menstrual period? _____			
18. 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)?				EXPLAIN "YES" ANSWERS BELOW list the number you are clarifying/explaining			
				•			
				•			
				•			
				•			
19. Has anyone in your family had a pacemaker or an implanted defibrillator before age 50?				•			
BONE AND JOINT QUESTIONS				•			
20. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?				•			
21. Do you currently have a bone, muscle, or joint injury that bothers you?							
MEDICAL QUESTIONS				List medications and nutritional supplements you are currently taking here:			
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?							
23. Do you have asthma or use asthma medicine (inhaler, nebulizer)?							

→ Parent/Guardian Signature: _____ Date: _____ → Athlete's Signature: _____

PART III- PHYSICAL EXAMINATION

(Pre-participation Physical may not be completed/signed by a parent/guardian even if a licensed healthcare professional)

NAME _____ DATE OF BIRTH _____ SCHOOL _____

Height		Weight					
BP	/	RR	Resting pulse	Vision	R 20/	L 20/	Corrected Yes No
Pediatric Population > 13 years and older within normal limits =				BP (F) 102-121/64-79 mmHg		BP (M) 102-124/64-80mmHg	
				RR 12-20 breaths per minute		Pulse 55-90bpm	
MEDICAL				NORMAL	ABNORMAL FINDINGS		
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)							
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)							
Consider ECG, Echocardiogram, and referral to cardiology if abnormal cardiac history/exam or family history to address Sudden Cardiac Arrest & Sudden Cardiac Death risk.							
Consider cognitive evaluation or baseline neuropsychiatric testing if history of significant prior to concussion.							
Emergency medications required on-site: Inhaler Epinephrine Glucagon Other:							
COMMENTS:							

I have reviewed the data above, reviewed the student's medical history form and make the following commendations for the students' participation in athletics:

Healthcare Professional completed and reviewed a Mental Health Screening with the athlete.

MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION

MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATION FOR FURTHER EVALUATION OR TREATMENT OF:

MEDICALLY ELIGIBLE ONLY FOR THE FOLLOWING SPORTS: _____

Reason: _____

NOT MEDICALLY ELIGIBLE FOR ANY SPORTS

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

→ PRACTITIONER SIGNATURE: _____ (MD, DO, NP or PA) + **DATE****: _____

EXAMINER'S NAME AND DEGREE (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.

PART IV- EMERGENCY INFORMATION FORM* (To be completed and signed by the parent/guardian)

Please Print

STUDENT'S NAME: _____ GRADE: _____ AGE: _____ DOB: _____

SPORT(S): _____

Please list any significant health problems that might be significant to a physician evaluating your child **in case of an emergency:**

PLEASE LIST ANY ALLERGIES TO MEDICATIONS, ETC:

IS THE STUDENT CURRENTLY PRESCRIBED AN INHALER? (circle only one)
YES OR NO

IS THE STUDENT CURRENTLY PRESCRIBED AN EPI PEN? (circle one one)
YES OR NO

Primary Contact Name: _____ **Relationship to student:** _____

DAYTIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

EVENING PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

CELL PHONE NUMBER: _____

Secondary Contact Name: _____ **Relationship to student:** _____

DAYTIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

EVENING PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

CELL PHONE NUMBER: _____

→ I CERTIFY ALL OF THE ABOVE INFORMATION IS CORRECT: _____

Parent/Guardian signature

Date: _____ **PARENT/GUARDAIN NAME (PLEASE PRINT)** _____

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.



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 2026-2027 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: _____

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 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 treatment of our child and agree to provide proof of insurance coverage for our child against accidents and injuries in school sponsored games, and practice sessions, and during travel to and from athletic contests.

Students who have decided 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 paid timely, 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 athletes' 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: _____ Email: _____

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