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**Last Name, First Name**  
*Name of Athlete*

# CARROLL COUNTY



# ATHLETICS

Carroll County Public Schools  
Athletic Preparticipation Physical Evaluation  
**To be completed by Parent/Guardian prior to physical exam**

Explain "Yes" answers below

Circle questions you do not know the answers to.

- |   | Yes | No  |
|---|-----|-----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?  | ___ | ___ |
| 2. Do you have a recurrent medical condition? (e.g., diabetes or asthma)  | ___ | ___ |
| 3. Are you currently taking any prescription or nonprescription (over-the counter) medicines?   | ___ | ___ |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?   | ___ | ___ |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise?  | ___ | ___ |
| 6. Have you experienced general dizziness when exercising?  | ___ | ___ |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?   | ___ | ___ |
| 8. Has a doctor ever ordered a test for your heart? (e.g., ECG, echocardiogram)   | ___ | ___ |
| 9. Has a doctor ever told you that you have (check all that apply)  |     |     |
| <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur  |     |     |
| <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection  |     |     |
| 10. Does anyone in your family have a heart problem?  | ___ | ___ |
| 11. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:   | ___ | ___ |
| 12. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | ___ | ___ |

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

- |  |     |     |
|--|-----|-----|
| 13. Have you ever had a stress fracture?   | ___ | ___ |
| 14. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | ___ | ___ |
| 15. Have you ever used an inhaler or taken asthma medicine?  | ___ | ___ |
| 16. Were you born without or are missing a kidney or any other organ?                              | ___ | ___ |
| 17. Have you ever had a head injury or concussion? If yes, when _____                              | ___ | ___ |
| 18. Have you ever had a seizure?   | ___ | ___ |
| 19. Have you had any problems with your eyes or vision?  | ___ | ___ |
| 20. Do you have a history of heat intolerance?   | ___ | ___ |
| 21. Do you have any current skin rashes/open areas or past history with MRSA?                      | ___ | ___ |
| 22. Have you had Mononucleosis (Mono)? If yes, when _____  | ___ | ___ |
| 23. Have you been diagnosed with Marfan's Syndrome?  | ___ | ___ |
| 24. (Females) Date of last menses _____  |     |     |
| 25. Do you have any concerns that you would like to discuss with a doctor?                         | ___ | ___ |

Explain "Yes" answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of Athlete \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

2004 American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine

**CARROLL COUNTY PUBLIC SCHOOLS  
ATHLETIC PARTICIPATION  
HEALTH EXAMINATION FORM AND PARENT PERMISSION FORM**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex M or F  
 Home Address \_\_\_\_\_ School \_\_\_\_\_  
 Parents' Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 Grade \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_  
 Eyes \_\_\_\_\_ R 20/ \_\_\_\_\_; L 20/ \_\_\_\_\_; Ears \_\_\_\_\_ Hearing R 15/ \_\_\_\_\_; L 15 \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary +			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Leg/ankle			
Foot/toes			

+ Having a third party present is recommended for the genitourinary examination

Notes: \_\_\_\_\_

**CLEARANCE**

- Cleared without restriction  
 Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
 Not cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

**EMERGENCY INFORMATION**

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

IMMUNIZATIONS  Up to date (See attached documentation)  Not up to date Specify \_\_\_\_\_

Date of last tetanus \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_

Date of examination \_\_\_\_\_

Physician's Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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**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:

- Have read the Guide for Student Athletes and Parents.
- Have read the provisions of the Authorization for Participation Interscholastic Athletics Form.
- Understand the eligibility standards.

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. Please check appropriate space:

I have: School Insurance

_____ School Time Student Accident	_____ No Insurance
_____ 24 Hour Student Accident	_____ Other Insurance-Family sponsored
_____ Voluntary Interscholastic Football*	

\_\_\_\_\_  
 Name of company & Policy number

\_\_\_\_\_  
 (Student’s Signature)

\_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 (Parent/Legal Guardian’s Signature)

\_\_\_\_\_  
 (Date)

\* Varsity Football coverage required if parents **DO NOT** maintain other health/accident insurance.

Note: JV football players who become varsity football players **MUST** have Voluntary Interscholastic Football insurance or family sponsored Health Care insurance.