



Carroll Christian Schools Athletic Perparticipation Physical Form

Please make sure you and your student review the student athlete handbook prior to participating in extracurricular athletics including eligibility requirements.

In order for your student athlete to participate in practices or games, the following forms must be completed. Please review the forms carefully and complete all fields. In the event your student is unable to be seen by their primary provider (often due to scheduling conflicts and/or insurance barriers), there is the option to have an athletic physical completed at an urgent care center.

Part II - Medical History form: To be completed by the student's parent/guardian and **taken to the student's provider** who will be completing the athletic physical assessment to review. The form requires a signature from the parent/guardian, as well as the student.

Part III - Physical Examination form: Must be completed in its entirety by the student's healthcare provider.

Authorization for Participation in Interscholastic Athletics form. This form is a legal statement authorizing consent for your student to participate in interscholastic sports with Carroll Christian Schools. This form must also be signed by the parent/guardian and student.

The information provided within the athletic physical packet is considered confidential medical records. The confidentiality of a student's medical records is protected under the federal Family Education Rights and Privacy Act (FERPA) and Maryland state law.

Students who require medication at school (including during team practices or games) must have a Physicians Medication Order Form (found on the school website under info, then documents) on file with the school nurse for each medication. This form must be completed yearly if applicable.

Athletic physicals are valid for one year from the date of their completion. Please return the completed packet to the school office.

Thank you and we look forward to having your student participate in athletics at Carroll Christian Schools!

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

→ 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		Sex Assigned at Birth		
BP /	RR	Resting pulse	Vision R 20/	L 20/	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No
Pediatric Population > 13 years and older within normal limits =			BP (F) 102-121/64-79 mmHg	BP (M) 102-124/64-80 mmHg	
			RR 12-20 breaths per minute	Pulse 55-90 bpm	
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: <input type="checkbox"/> Inhaler <input type="checkbox"/> Epinephrine <input type="checkbox"/> Glucagon <input type="checkbox"/> 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.



AUTHORIZATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

As parents or legal guardians of _____ we hereby authorize and consent to our child's participation in interscholastic athletics and sports. We understand that the sport in which our child will be participating is potentially dangerous, and that physical injuries may occur to our child requiring emergency Carroll Christian Schools 550 Baltimore Blvd., Westminster, MD 21157 Email: ccs-administration@carrollchristian.com fax: 410-876-7766 phone: 410-876-3838 Rev. 11/2016 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 athletics and sports. In consideration of the acceptance of our child by Carroll Christian Schools in its athletic program, we agree to release and hold harmless the leadership of Church of the Open Door and Carroll Christian Schools, its members, the principal, all coaches, and assistant coaches, and any and all other of their 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 athletics and sports. We hereby give our consent and authorize the administration of Carroll Christian Schools 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 attempts 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 care 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 at Carroll Christian Schools as approved by the school administration. 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 the child is insured from the first day of practice to the last day of post-season competition. Carroll Christian Schools is not an insurer, and, under no circumstances, will Carroll Christian Schools, its members, agents, employees, or insurers be held liable for any injury or death arising out of a child's participation in interscholastic athletics or sports, or as a result of inadequate insurance coverage. By evidence of the signature below, you are testifying that you: • Have read the Handbook for Student Athletes and Parents • Understanding 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 athletic program of Carroll Christian Schools. Please check the appropriate space: I have: 1 No insurance 1 Other Insurance (family sponsored)

_____ Student's Signature Date _____

_____ Parent/Legal Guardian's Signature Date _____