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

# CARROLL COUNTY



# ATHLETICS



# CARROLL COUNTY PUBLIC SCHOOLS

## PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP / ( / )	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) <sup>b</sup>		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

SPORT(S): \_\_\_\_\_  
GRADE: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_

- a Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
 b Consider GU exam if in private setting. Having third party present is recommended.  
 c Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction  
 Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_  
 Not cleared  
 Pending further evaluation  
 For any sports  
 For certain sports \_\_\_\_\_  
 Reason \_\_\_\_\_

Recommendations \_\_\_\_\_  
 \_\_\_\_\_

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

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

Address \_\_\_\_\_ Phone \_\_\_\_\_

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

LAST NAME: \_\_\_\_\_

**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.