

Cecil County Public Schools Interscholastic Athletics MEDICAL HISTORY FORM (PARENT'S SECTION) (Grades 6-12)

Name: _____ DOB: _____

Sex: M / F Age: _____ Grade: _____ School: _____

Child's Physician: _____ Phone: _____

DIRECTIONS: Please check box for "Yes" or "No" and explain "Yes" answers in the space below.


1. Have you ever had a medical illness or injury since your last check up or sports physical?	YES	NO	20. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	YES	NO		
2. Are you currently taking a prescription or non-prescription (over-the counter) medications?			21. Do you cough, wheeze, or have trouble breathing during or after activity?				
3. Have you ever been hospitalized overnight?			22. Do you have asthma?				
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?			23. Do you have seasonal allergies that require medical treatment?				
5. Have you ever passed out or been dizzy during or after exercise?			24. Do you have diabetes? Use insulin?				
6. Have you ever had chest pain during or after exercise?			25. Do you lose weight regularly to meet weight requirements for your sport?				
7. Have you ever become ill from exercising in the heat?			26. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?				
8. Have you ever had racing of your heart or skipped heartbeats?							
9. Have you had high blood pressure or high cholesterol?			27. Have you ever had any problems with your eyes or vision? Wear glasses or contacts?				
10. Have you ever been knocked out, become unconscious, or lost your memory?			28. Have you ever been told you have a heart murmur?				
11. Has any family member or relative died of heart problems or of sudden death before age 50?			29. Have you ever had a sprain, strain, or swelling after injury?				
12. Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month?			30. Have you broken or fractured any bones or dislocated any joints? 31. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If "Yes", circle appropriate area and explain below:				
13. Has a physician ever denied or restricted your participation in sports for any heart problems?							
14. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?							
15. Have you ever had a head injury or concussion?							
16. Have you ever had a stinger, burner, or pinched nerve?			Head	Elbow	Hip	Neck	Foot
			Forearm	Thigh	Back	Wrist	Knee
			Chest	Hand	Shin/Calf	Upper Arm	
			Shoulder	Finger	Ankle		
17. Have you ever had a seizure?			32. Do you have any communicable diseases?				
18. Do you have frequent or severe headaches?			33. Do you have Marfan's Syndrome?				
19. Do you have sickle cell trait?			34. Are you easily fatigued?				

Explain "Yes" answers on an additional sheet.

By signing below,

- I understand and agree that student athletes are not to use tobacco, alcohol, or other drugs at any time. (Reference: Interscholastic Regulations, Policies, and Procedures Handbook) Any substantiated reported use of alcohol, tobacco, or other drugs in school will be handled in accordance to 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 a physical examination, and/or assist in rendering a physical examination, on 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 except those activities crossed out by the examining physician on the reverse side of this form.

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**

BLOOD PRESSURE

Patient's Name: _____ DOB: _____ Height: _____ Weight: _____

Vision: R 20/ _____ L 20/ _____ Corrected? Yes No Pupils: Equal _____ Unequal _____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/ Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Beighton-Horan Laxity Screen Score: _____ (Out of 9)

CLEARANCE: I have on this date, personally examined this pupil, reviewed the history and other data recorded on both sides of this form. I find this student physically able to compete in the interscholastic sports listed below which are NOT crossed out.

- | | | | | | |
|------------|---------------|--------------|----------|---------------|---------------|
| Basketball | Cheerleading | Field Hockey | Football | Golf | Lacrosse |
| Soccer | Baseball | Softball | Tennis | Track & Field | Volleyball |
| Wrestling | Cross Country | Bocce | Bowling | Flag Football | Marching Band |

This student is physically able to work in the "Construction Field" at the School of Technology YES NO

NOT Cleared Reason/ Recommendations: _____

Name of physician and Office (print/type): _____

Address: _____ Office Phone: _____

Must be dated on or after JUNE 1.

Signature of Attending Physician: _____ Date Signed: _____

TO BE SIGNED BY 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: _____ 