Student Athlete and Parent Packet

Office of Interscholastic Athletics
4400 Shell Street
Capitol Heights, MD 20743
Phone: 301-669-6000 www.pgcps.org

Earl Hawkins, Coordinating Supervisor
Interscholastic Athletics

O'Shay Watson, Supervisor
Interscholastic Athletics

Member of the Maryland Public Secondary Public Schools Athletic Association
Parental Permission for Participation in Interscholastic Athletics

Please fill in the appropriate blanks and return this form to the head coach of the sport in which you wish your son/daughter to participate. Permission to participate is not granted unless this form is signed by the parent or legal guardian. Permission applies only to the sport specified. A new form must be submitted if guardianship or insurance information changes.

My child, ____________________________, has my permission to participate in the following Prince George's County athletic program for the school year ________:

SPORT ____________________________
SCHOOL __________________________

Parent/Guardian Signature ____________________________ Date ____________

Address __________________________

Home Phone __________________________ Work Phone __________________________

The school does not provide insurance coverage for athletes other than the group catastrophic policy for football programs. All participants should have their own insurance coverage in effect at the time of participation to cover accidental injuries that might arise.

My child has injury insurance coverage under policy # __________________________ through __________________________ Insurance Company __________________________

Parent/Guardian Signature __________________________ Date ____________

In case of an emergency in which your child needs immediate medical treatment, we will send him/her to the nearest hospital and notify you immediately. The phone numbers you supply are of the utmost importance and should be updated when a change occurs. Please list your doctor's name and phone number so that he may be contacted if necessary:

Name of Doctor __________________________

Phone Number(s) __________________________
Preparticipation Physical Evaluation

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam ____________________________ Date of birth ____________________________

Name ____________________________ Sex ______ Age ______ Grade ______ School ______ Sport(s) ______

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes ______ No ______ If yes, please identify specific allergy below.

□ Medicines □ Pollens □ Food □ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes ______ No ______

2. Do you have any ongoing medical conditions? If so, please identify below: □ Asthma □ Arthritis □ Diabetes □ Infections Other: ______

3. Have you ever spent the night in the hospital? Yes ______ No ______

4. Have you ever had surgery? Yes ______ No ______

HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out DURING or AFTER exercise? Yes ______ No ______

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Yes ______ No ______

7. Does your heart ever race or skip beats (irregular beats) during exercise? Yes ______ No ______

8. Has a doctor ever told you that you have a heart problem? If so, check all that apply: □ High blood pressure □ A heart murmur □ High cholesterol □ A heart infection □ Kawasaki disease □ Other: ______

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) Yes ______ No ______

10. Do you get lightheaded or feel more short of breath than expected during exercise? Yes ______ No ______

11. Have you ever had an unexplained seizure? Yes ______ No ______

12. Do you get more tired or short of breath more quickly than your friends during exercise? Yes ______ No ______

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

13. Has any family member or relative died of heart problems or had an unexplained or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? Yes ______ No ______

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? Yes ______ No ______

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Yes ______ No ______

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? Yes ______ No ______

BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? Yes ______ No ______

18. Have you ever had any broken or fractured bones or dislocated joints? Yes ______ No ______

19. Have you ever had an injury that required x-rays, MRI, CT scan, or injections, therapy, a brace, a cast, or crutches? Yes ______ No ______

20. Have you ever had a stress fracture? Yes ______ No ______

21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or disorder) Yes ______ No ______

22. Do you regularly use a brace, orthotics, or other assistive device? Yes ______ No ______

23. Do you have a bone, muscle, or joint injury that bothers you? Yes ______ No ______

24. Do any of your joints become painful, swollen, feel warm, or look red? Yes ______ No ______

25. Do you have any history of juvenile arthritis or connective tissue disease? Yes ______ No ______

MEDICAL QUESTIONS

26. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes ______ No ______

27. Have you ever used an inhaler or taken an asthma medicine? Yes ______ No ______

28. Is there anyone in your family who has asthma? Yes ______ No ______

29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? Yes ______ No ______

30. Do you have groin pain or a painful lump or hernia in the groin area? Yes ______ No ______

31. Have you had infectious mononucleosis (mono) within the last month? Yes ______ No ______

32. Do you have any rashes, pressure sores, or other skin problems? Yes ______ No ______

33. Have you had a herpes or MRSA skin infection? Yes ______ No ______

34. Have you ever had a head injury or concussion? Yes ______ No ______

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? Yes ______ No ______

36. Do you have a history of seizure disorder? Yes ______ No ______

37. Do you have headaches with exercise? Yes ______ No ______

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Yes ______ No ______

39. Have you ever been unable to move your arms or legs after being hit or falling? Yes ______ No ______

40. Have you ever become ill while exercising in the heat? Yes ______ No ______

41. Do you get frequent muscle cramps when exercising? Yes ______ No ______

42. Do you or someone in your family have sickle cell trait or disease? Yes ______ No ______

43. Have you had any problems with your eyes or vision? Yes ______ No ______

44. Have you had any eye injuries? Yes ______ No ______

45. Do you wear glasses or contact lenses? Yes ______ No ______

46. Do you wear protective eyewear, such as goggles or a face shield? Yes ______ No ______

47. Do you worry about your weight? Yes ______ No ______

48. Are you trying to or has anyone recommended that you gain or lose weight? Yes ______ No ______

49. Are you on a special diet or do you avoid certain types of foods? Yes ______ No ______

50. Have you ever had an eating disorder? Yes ______ No ______

51. Do you have any concerns that you would like to discuss with a doctor? Yes ______ No ______

FEMALES ONLY

52. Have you ever had a menstrual period? Yes ______ No ______

53. How old were you when you had your first menstrual period? ______

54. How many periods have you had in the last 12 months? ______

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 ________________


HR0538 9-2011/0410
**Preparticipation Physical Evaluation**

**The Athlete with Special Needs: Supplemental History Form**

Date of Exam ___________________________ Date of birth ___________________________

Name ___________________________ Grade ___________________________ School ___________________________ Sport(s) ___________________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident-trauma, other)
5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>6. Do you regularly use a brace, assistive device, or prosthetic?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
<td></td>
<td></td>
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<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
<td></td>
<td></td>
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<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
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<tr>
<td>10. Do you have a visual impairment?</td>
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<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td></td>
<td></td>
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<tr>
<td>13. Have you had autonomic dysreflexia?</td>
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<tr>
<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
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<td></td>
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<tr>
<td>15. Do you have muscle spasticity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
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<td></td>
</tr>
</tbody>
</table>

Explain "yes" answers here

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Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial Instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis or osteopenia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
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<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
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<td></td>
</tr>
</tbody>
</table>

Explain "yes" answers here

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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 ___________________________

# Preparticipation Physical Evaluation

**PHYSICAL EXAMINATION FORM**

Name: ___________________________ Date of birth: __________

**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever used inhaled or smoked marijuana, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, or use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

## EXAMINATION

<table>
<thead>
<tr>
<th>BP</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
<th>Pulse</th>
<th>Vision R 20/70</th>
<th>Vision L 20/70</th>
<th>Corrected</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
</table>

- **Appearance**
  - Marfan stigmata (hypospadias, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlordosis, myopia, MVP, aortic insufficiency)

- **Eyes/ears/nose/throat**
  - Pupil size equal
  - Hearing

- **Lymph nodes**

- **Heart**
  - Murmurs (auscultation standing, supine, +/- Valsalva)
  - Location of point of maximal impulse (PMI)

- **Pulses**
  - Simultaneous femoral and radial pulses

- **Lungs**

- **Abdomen**

**Genitourinary (males only)**

- **Skin**
  - HSV, lesions suggestive of MRSA, tinea corporis

**Neurologic**

**MUSCULOSKELETAL**

- **Neck**
- **Back**
- **Shoulder/arm**
- **Elbow/forearm**
- **Wrist/hand/fingers**
- **Hip/thigh**
- **Knee**
- **Leg/ankle**
- **Foot/toes**

**Functional**

- Duck-walk, single leg hop

*Consider EKG, echocardiogram, and referral to cardiologist for abnormalities or cardiac history or exam.

*Consider EKG exam if in private setting. Having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychologic testing if a history of significant concussions.

☐ 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

Preparticipation Physical Evaluation
CLEARANCE FORM

Name ________________________________ Sex □ M □ F Age __________ Date of birth __________

☐ 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

EMERGENCY INFORMATION

Allergies ________________________________

______________________________

______________________________

______________________________

______________________________

Other information ________________________________

______________________________

______________________________

______________________________

______________________________

MEDICAL CARD FOR ATHLETE

Office of Interscholastic Athletics
PRINCE GEORGE'S COUNTY PUBLIC SCHOOLS

INSTRUCTIONS: This card should be kept on file in the medical kit for each sport. It should accompany the athlete to the doctor or hospital when medical attention is required.

School Name ___________________________ Jersey Number ___________________________

Student Name ___________________________ Phone # (_____) ___________________________

Home Address ___________________________ Alternate

Date of Birth ________ / ________ / ______

Physician

Phone # (_____) ___________________________

Tetanus Shot ________ / ________ / ______

Date of Last

Family Physician ___________________________ Phone # (_____) ___________________________

Hospital Preference ___________________________

Allergies ___________________________

Medicine Administered on the Field ___________________________

(OVER)
MEDICAL CARD FOR ATHLETE

INSURANCE INFORMATION:

Does your son/daughter have medical insurance? □ Yes  □ No

If Yes, name of insurance company __________________________________________________________

RELEASE FOR TREATMENT:

I hereby give permission to the attending physician or hospital to administer appropriate medical treatment in the event I cannot be reached.

_________________________________________  __________/_____/______
Signature, Parent/Guardian                  Date

This Card Must Be Kept On File In The Medical Kit For Each Sport. It Must Accompany The Athlete To The Doctor Or Hospital When Medical Attention Is Required.
Throughout the school year, the Board of Education of Prince George's County and individual schools within Prince George's County Public Schools will conduct activities that may be publicized through local or national news media. These activities may include interview sessions with news reporters; photographs of individual students or groups of students for newspapers or various school system publications including newsletters, calendars, and brochures; the use of student photos on the PGCPS Web site; and videotaping for local and national television news programs, cable programming, and school system promotional videos.

Please check one of the two statements below. Sign and return this document to your child's school.

☐ I/we grant permission for my child's classwork, tests or assignments, with comments and/or grades, to be displayed.

☐ I/we grant permission for my/our child's name, voice, and photographic likeness to be used by Prince George's County Public Schools personnel, reporters, journalists, or photographers employed by news media.

☐ I/we do not give permission for my child's name, voice, and photographic likeness to be used by Prince George's County Public Schools personnel, or reporters, journalists, or photographers employed by news media.

________________________________________________________________________
Child's Name

________________________________________________________________________
Signature of Parent(s) or Guardian(s)

________________________________________________________________________
School

________________________________________________________________________
Signature of Parent(s) or Guardian(s)

________________________________________________________________________
Date

Prince George’s County Board of Education
Prince George’s County Public Schools • www.pgcps.org • 14201 School Lane • Upper Marlboro, MD 20772

FEBRUARY 2014
AUTORIZACIÓN PARA PUBLICAR

Durante el transcurso del ciclo lectivo, la Junta Educativa del Condado de Prince George y cada establecimiento del sistema de Escuelas Públicas del Condado de Prince George llevarán a cabo actividades que podrán publicarse en los medios de comunicación local o nacional. Entre otras, tales actividades incluyen: entrevistas con periodistas, fotografías individuales o grupales de los alumnos para periódicos o publicaciones del sistema escolar (boletines de noticias, calendarios, folletos, etc.), uso de fotografías en el sitio Web de PGCPS; y filmación para noticieros televisivos locales y nacionales, programación de cable y filmación de videos promocionales del sistema escolar.

Por favor, responda marcando una respuesta a continuación. Firme y envíe de regreso este documento a la escuela de su hijo.

☐ Yo/Nosotros otorgamos permiso para que el trabajo en clase, pruebas o tareas de mi hijo, con comentarios y/o grados, sea mostrado.

☐ Autorizo/Autorizamos la utilización del nombre, la voz, o representación fotográfica de mi/nuestro hijo por parte del personal de las Escuelas Públicas del Condado de Prince George o por parte de redactores, periodistas o fotógrafos de los medios noticiosos.

☐ No autorizo/autorizamos la utilización del nombre, la voz, o representación fotográfica de mi/nuestro hijo por parte del personal de las Escuelas Públicas del Condado de Prince George o por parte de redactores, periodistas o fotógrafos de los medios noticiosos.

________________________________________________________________________
Nombre del alumno

Escuela

Firma del padre o tutor

Firma del padre o tutor

Fecha