2013-2014
ATHLETIC PAPERWORK* REQUIRED
TO PARTICIPATE IN UNIFIED SPORTS®

*concussion forms updated 6/17/2013

NAME OF ATHLETE: _____________________

SCHOOL: ______________________
Join your school’s Unified Sports® Teams! This year (2013-2014), all 10 FCPS high schools will have Unified Sports® teams competing in the fall, winter, and spring seasons. These athletic teams will be comprised of students with and without disabilities competing as teammates alongside each other during competition.

The fall sport will be tennis. The winter sport will be indoor bocce ball. And the spring sport will be track and field. All programs are FREE!

QUESTIONS???
CONTACT YOUR SCHOOL’S:

UNIFIED® COACHES,
ATHLETIC DIRECTOR, or
SPECIAL EDUCATION STAFF
APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS MARYLAND

PARTICIPANT NAME

E-MAIL ADDRESS

School/Agency

Gender

Date of Birth

Does student have a disability? YES ☐ NO ☐

If ‘YES’, PLEASE CHOOSE ALL THAT APPLY:

☐ Autism
☐ Deaf – Blindness
☐ Developmental Delay
☐ Intellectual Disability
☐ Specific Learning Disability
☐ Traumatic Brain Injury
☐ Multiple Disabilities, Cognitive (specify)
☐ Multiple Disabilities, Physical (specify)

Do you use illegal drugs? ☐ ☐ ☐ ☐ ☐

IF YOU ANSWERED YES TO THE ABOVE QUESTION, PLEASE EXPLAIN THE DATES AND DETAILS OF EACH CASE ON A SEPARATE SHEET OF PAPER

Special Olympics Maryland activities, and I do not possess any information that would cause me to believe Applicant would pose any undue risk to other Special Olympics Maryland participants.

Home Phone Number: (____) ________________________ Work Phone Number: (____) _________________________

Signature of Participant

Date: ___________________

Parent/Guardian if Participant is 17 years old or younger.

______________________________________________

Date: ___________________

Students/Minors (those individuals 17 years old or younger) must complete this Student/Minor Reference Section

List (1) adult, NON-FAMILY reference: please print all information. (Coach, Assistant Coach, Teacher, Neighbor are all acceptable references)

Reference # 1: Complete Name: ___________________________ Relationship to Applicant ___________________________

Home Address: ______________________________________ City: ___________________ State: ______ Zip: ______

Home Phone Number: (____) _________________________ Work Phone Number: (____) _________________________

By signing below I certify that I am at least 18 years of age and not a legal guardian or relative of Applicant. I am not aware of any reason that Applicant should not be permitted to participate in Special Olympics Maryland activities, and I do not possess any information that would cause me to believe Applicant would pose any undue risk to other Special Olympics Maryland participants or volunteers.

Signature of Reference: ___________________________________________________________ Date: ___________________

Signature of Participant

Date: ___________________

Signature of Parent/Guardian if Participant is 17 years old or younger.

______________________________________________

Date: ___________________

Rev 6 / 2012
# 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 ____________________________________________  
Name _________________________________________________  
Sex ______ Age ______ Grade ______ School ______ Sport(s) ______  
Date of birth ____________________________________________  

<table>
<thead>
<tr>
<th>Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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  ☐ Anemia  ☐ Diabetes  ☐ Infections  ☐ Other: ____________________________

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

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

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 any heart problems? 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 YOU

13. Has any family member or relative died of heart problems or had an unexpected 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 causes 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, 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 dwarfism)  
☐ 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 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 bulge 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?  
☐ Yes  ☐ No

54. How many periods have you had in the last 12 months?  
☐ Yes  ☐ No

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 ____________________________

Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS:
SUPPLEMENTAL HISTORY FORM

Date of Exam ____________________________________________

Name ___________________________________________________

Date of birth ___________________________________________

Sex _______ Age ________ 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

Yes | No
--- | ---

6. Do you regularly use a brace, assistive device, or prosthetic?
7. Do you use any special brace or assistive device for sports?
8. Do you have any rashes, pressure sores, or any other skin problems?
9. Do you have a hearing loss? Do you use a hearing aid?
10. Do you have a visual impairment?
11. Do you use any special devices for bowel or bladder function?
12. Do you have burning or discomfort when urinating?
13. Have you had autonomic dysreflexia?
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?
15. Do you have muscle spasticity?
16. Do you have frequent seizures that cannot be controlled by medication?

Explain “yes” answers here

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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

Atlantoaxial instability
X-ray evaluation for atlantoaxial instability
Dislocated joints (more than one)
Easy bleeding
Enlarged spleen
Hepatitis
Osteopenia or osteoporosis
Difficulty controlling bowel
Difficulty controlling bladder
Numbness or tingling in arms or hands
Numbness or tingling in legs or feet
Weakness in arms or hands
Weakness in legs or feet
Recent change in coordination
Recent change in ability to walk
Spina bifida
Latex allergy

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 __________

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 tried cigarettes, chewing tobacco, 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, and use condoms?

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

EXAMINATION

Height     Weight □ Male □ Female

BP / ( ) / Pulse Vision R 20/ L 20/ Corrected □ Y □ 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
• 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, linea 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

☐ 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 ______________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

AUTHORIZATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

Frederick County Public Schools

As parents or legal guardians of

First ( Please Print) Middle Last

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 medical care and treatment. We assume the risk of injury to our child that may occur in an athletic activity.

In consideration of the acceptance of our child by the Frederick County Public Schools in its athletic program, and the benefits derived by our child from participation, we agree to release and hold harmless the Board of Education of Frederick County, its members, the Superintendent of Schools, the principal, all coaches, and any and all other agents, servants, and/or employees and agree to indemnify each of them from any claims, costs, suits, actions, judgments, and expenses arising from our child’s participation in interscholastic athletics and sports.

We hereby give our consent and authorize the Board of Education of Frederick County 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, 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 Frederick County Public Schools as issued by the Frederick County Board of Education and the Maryland State Department of Education.

Every candidate for and participant on an interscholastic team must obtain and maintain insurance against possible accident or injury in school-sponsored games, practice sessions, and during travel to and from athletic contests. Such coverage may be provided by the purchase of scholastic accident insurance (through the school); otherwise, proof of similar or superior coverage must be presented. Football insurance must be purchased separately from other insurance options.

RESIDENCY REQUIREMENTS

I also declare and affirm that my child resides within the attendance area of:

(Name of School)

or is attending

(Name of School)

with the special permission of the Department of Student Services of Frederick County Public Schools. A student attending a high school without the benefit of residing* within the school’s attendance area and/or special permission of the Superintendent of Schools or his designee, is subject to disciplinary action which could result in the 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.

*Residing means with parents or legal custodians.
# STUDENT ATHLETE INFORMATION FORM

<table>
<thead>
<tr>
<th>Name (First, Middle, Last)</th>
<th>Grade</th>
<th>Age</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Birthdate</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>My son/daughter/ward is covered by medical insurance</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, Company Name, Policy Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, student must have school insurance</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Physician</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dentist</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Home Telephone Number</th>
<th>Emergency Telephone Number</th>
<th>E-mail Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Legal Home Address</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

| Parent/Legal Guardian Name | |
|-----------------------------||

<table>
<thead>
<tr>
<th>Year</th>
<th>High School(s) Attended</th>
<th>Grade</th>
<th>Sports Played</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Parents, please initial each item below.**

By evidence of the signatures below, you are testifying that you:

- [ ] Have read the athletic brochure
- [ ] Have read the provisions of the Authorization for Participation in Interscholastic Athletics form
- [ ] Understand the eligibility and residency requirements
- [ ] Understand the school system’s concussion policy
- [ ] Give permission for participation and assume risk for injury that may occur
- [ ] Acknowledge valid insurability by school or private insurance carrier
- [ ] Give permission for student’s name and picture to be used for internet and school publications

Failure to accurately complete, sign and return to your child's coach will result in his/her exclusion from participation in the interscholastic athletic program of the Frederick County Public Schools.

(Sport)

(Student's Signature) (Date)

(Parent/Legal Guardian Signature) (Date)

Revised 5/11
Concussion facts:

- A concussion is a brain injury that affects how your brain works.
- A concussion is caused by a bump, blow, or jolt to the head or body.
- A concussion can happen even if you haven’t been knocked out.
- If you think you have a concussion, you should not return to play on the day of the injury and not until a health care professional says you are OK to return to play.

What are the symptoms of a concussion?

Concussion symptoms differ with each person and with each injury, and they may not be noticeable for hours or days. Common symptoms include:

- Headache
- Confusion
- Difficulty remembering or paying attention
- Balance problems or dizziness
- Feeling sluggish, hazy, foggy, or groggy
- Feeling irritable, more emotional, or “down”
- Nausea or vomiting
- Bothered by light or noise
- Double or blurry vision
- Slowed reaction time
- Sleep problems
- Loss of consciousness

During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

What should I do if I think I have a concussion?

DON’T HIDE IT. REPORT IT. Ignoring your symptoms and trying to “tough it out” often makes symptoms worse. Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. Don’t let anyone pressure you into continuing to practice or play with a concussion.

GET CHECKED OUT. Only a health care professional can tell if you have a concussion and when it’s OK to return to play. Sports have injury timeouts and player substitutions so that you can get checked out and the team can perform at its best. The sooner you get checked out, the sooner you may be able to safely return to play.

TAKE CARE OF YOUR BRAIN. A concussion can affect your ability to do schoolwork and other activities. Most athletes with a concussion get better and return to sports, but it is important to rest and give your brain time to heal. A repeat concussion that occurs while your brain is still healing can cause long-term problems that may change your life forever.

How can I help prevent a concussion?

Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach’s rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If you think you have a concussion:

Don’t hide it. Report it. Take time to recover.

It’s better to miss one game than the whole season.

For more information, visit www.cdc.gov/Concussion.
What is a concussion?
A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

You can’t see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

What are the signs and symptoms of a concussion?
If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs of a concussion:

<table>
<thead>
<tr>
<th>SYMPTOMS REPORTED BY ATHLETE</th>
<th>SIGNS OBSERVED BY PARENTS/GUARDIANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache or “pressure” in head</td>
<td>Appears dazed or stunned</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
<td>Is confused about assignment or position</td>
</tr>
<tr>
<td>Balance problems or dizziness</td>
<td>Forgets an instruction</td>
</tr>
<tr>
<td>Double or blurry vision</td>
<td>Is unsure of game, score, or opponent</td>
</tr>
<tr>
<td>Sensitivity to light</td>
<td>Moves clumsily</td>
</tr>
<tr>
<td>Sensitivity to noise</td>
<td>Answers questions slowly</td>
</tr>
<tr>
<td>Feeling sluggish, hazy, foggy, or groggy</td>
<td>Loses consciousness (even briefly)</td>
</tr>
<tr>
<td>Concentration or memory problems</td>
<td>Shows mood, behavior, or personality changes</td>
</tr>
<tr>
<td>Confusion</td>
<td></td>
</tr>
<tr>
<td>Just “not feeling right” or “feeling down”</td>
<td></td>
</tr>
</tbody>
</table>

How can you help your child prevent a concussion or other serious brain injury?
- Ensure that they follow their coach’s rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
  - However, helmets are not designed to prevent concussions. There is no “concussion-proof” helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

What should you do if you think your child has a concussion?
SEEK MEDICAL ATTENTION RIGHT AWAY. A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.

KEEP YOUR CHILD OUT OF PLAY. Concussions take time to heal. Don’t let your child return to play the day of the injury and until a health care professional says it’s OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a repeat concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

TELL YOUR CHILD’S COACH ABOUT ANY PREVIOUS CONCUSSION. Coaches should know if your child had a previous concussion. Your child’s coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

If you think your teen has a concussion:
Don’t assess it yourself. Take him/her out of play. Seek the advice of a health care professional.

It’s better to miss one game than the whole season.
For more information, visit www.cdc.gov/Concussion.
Concussion Awareness
Parent/Student-Athlete Acknowledgement Statement

I ______________________________, the parent/guardian of ______________________,
Parent/Guardian            Name of Student-Athlete

acknowledge that I have received information on all of the following:

- The definition of a concussion
- The signs and symptoms of a concussion to observe for or that may be reported by my athlete
- How to help my athlete prevent a concussion
- What to do if I think my athlete has a concussion, specifically, to seek medical attention right away, keep my athlete out of play, tell the coach about a recent concussion, and report any concussion and/or symptoms to the school nurse.

Parent/Guardian_________________ Parent/Guardian___________________ Date __________
PRINT NAME     SIGNATURE

Student Athlete__________________ Student Athlete____________________ Date __________
PRINT NAME     SIGNATURE

It’s better to miss one game than the whole season.
For more information visit: www.cdc.gov/Concussion.
PRE-PARTICIPATION HEAD INJURY/CONCUSSION REPORTING FORM FOR EXTRACURRICULAR ACTIVITIES

This form should be completed by the student’s parent(s) or legal guardian(s). It must be submitted to the Athletic Director, or official designated by the school, prior to the start of each season a student’s plans to participate in an extracurricular athletic activity.

Student Information

Name:

Grade:

Sport(s):

Home Address:

Has student ever experienced a traumatic head injury (a blow to the head)? Yes______ No______
If yes, when? Dates (month/year): ________________________________

Has student ever received medical attention for a head injury? Yes______ No______
If yes, when? Dates (month/year): ________________________________
If yes, please describe the circumstances:

Was student diagnosed with a concussion? Yes______ No______
If yes, when? Dates (month/year): ________________________________
Duration of Symptoms (such as headache, difficulty concentrating, fatigue) for most recent concussion:

Parent/Guardian: Name: ________________________________ (Please print)

Signature/Date ________________________________

Student Athlete: Signature/Date ________________________________
Transportation of Student(s) to and from FCPS Activities and Events

School Year: ____________

Parental Permission

If bus transportation is not provided by the Board of Education of Frederick County, I understand and affirm as the parent/guardian of the student(s) named below that I accept full responsibility for the transportation of my child/children to and from Frederick County Public Schools activities and events, including those events on school property as well as off-site locations (i.e., athletic team events, field trips, extracurricular activities) as identified below:

Student(s): __________________________________________________________

_________________________________________________________________

Event/Activity/Sports Season (i.e., year):

_________________________________________________________________

_________________________________________________________________

I understand that the Board of Education of Frederick County is not liable for any resulting injuries or loss associated with these travel arrangements and further acknowledge that any liability is primarily assured by the private driver’s automobile insurance.

___________________________________________  __________________________
Signature of Parent/Guardian     Date

Authorized:  _________________________________  _____________________________
Signature of Principal      Date

REFERENCE: FCPS Regulation 400-46
STUDENT ATHLETE INFORMATION CARD

YOUR STUDENT

Student’s Name __________________________________  ___________________________  _____
Last                                                                                                                First                                                                           MI
Home Phone _______________________   Birthdate _________________  Sex _____  Grade _____
Street Address _____________________________________________________________________
City _________________________________________________________ Zip Code  ___________

Parent/Guardian #1: Parent/Guardian #2: Alt Emergency Contact:
Name Mr/Ms Mr/Ms Mr/Ms
Phone (H)
Phone (W)
Phone (cell)
Alt Phone
Employer

In the course of school activities, FCPS staff and/or the news media occasionally wish to interview, photograph or videotape
students, display their work or publish their names. Unless indicated otherwise below, we will assume permission to do so.
(FCPS cannot control media coverage of events that are open to the public.)  Permission refused __________

In case of accident or serious illness, I request that school staff attempt to contact me. If I cannot be reached, I hereby authorize
the head coach or assistant coach to make reasonable arrangements to be in the best interest of the child.
Signature of Parent or Guardian     Date

PARENTS/GUARDIANS

Signature of Parent or Guardian __________________________________________   Date __________________________
HEALTH AND EMERGENCY INFORMATION

HEALTH CARE CONTACTS

Health Care Provider/Physician_________________________ Phone _____________________________
Dentist_____________________________________________ Phone _____________________________
Health Insurance Co. __________________________________ Phone _____________________________

STUDENTS’ MEDICAL HISTORY (CHECK THOSE THAT APPLY):

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>Dental Problem</td>
<td>Kidney/Bladder Problems</td>
</tr>
<tr>
<td>ADD</td>
<td>Diabetes</td>
<td>Menstrual Problems</td>
</tr>
<tr>
<td>Allergy: Bee Sting</td>
<td>Disability – Physical</td>
<td>Orthopedic Condition</td>
</tr>
<tr>
<td>Allergy: Food</td>
<td>Earaches/Infections – Frequent</td>
<td>Seizure Disorder</td>
</tr>
<tr>
<td>Allergy: Latex</td>
<td>Eczema</td>
<td>Sore Throats – Frequent</td>
</tr>
<tr>
<td>Allergy: Medication</td>
<td>Fainting Spells</td>
<td>Speech Problem</td>
</tr>
<tr>
<td>Allergy: Pesticide/Chemical*</td>
<td>Gastrointestinal Disorder</td>
<td>Stomachaches – Frequent</td>
</tr>
<tr>
<td>Allergy: Seasonal</td>
<td>Headaches – Frequent</td>
<td>Vision Problem –</td>
</tr>
<tr>
<td>Anorexia/Bulimia</td>
<td>Hearing Problem/Wears Aids</td>
<td>Wears Glasses/Contacts</td>
</tr>
<tr>
<td>Asthma</td>
<td>Heart Condition</td>
<td></td>
</tr>
</tbody>
</table>

If any of above was checked, please explain. Also include anything about child’s health that will help staff better understand and work with him/her. _________________________________________________________________________________________________

At Home: Y / N At School: Y / N

DOES YOUR CHILD NEED MEDICATION FOR ANY CONDITION? Name of Medication: ___________________________ Dosage: ___________________________

Reason Needed: ____________________________________________________________________________________

Reminder: You must supply medication form completed by a health care provider for each medicine the student takes at school.