



# Parental Consent Form

## Prince George's County Public School "DON'T GET BENCHED" Sports Physical Initiative

Dear Parents/Guardians,

Elaine Ellis Center of Health (EECH) is providing **Sports Physicals at your child's school**. If you wish for your child to participate, ***please legibly complete the following information***. Please also attach a copy of your picture identification card to further support your consent.

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Do we have your permission to call you? Yes \_\_\_ No \_\_\_ Text you? Yes \_\_\_ No \_\_\_ Email you? Yes \_\_\_ No \_\_\_

What school does your child attend? \_\_\_\_\_

Grade \_\_\_\_\_

### Additional Information

Who is your child's Primary Care Physician? \_\_\_\_\_

Is your child on any medication(s)? Yes \_\_\_ No \_\_\_ Name of medication? \_\_\_\_\_

Does your child have allergies to any medication(s)? Yes \_\_\_ No \_\_\_ Reaction: \_\_\_\_\_

Has your child had any past medical problems? Yes \_\_\_ No \_\_\_ or Surgery? Yes \_\_\_ No \_\_\_

If yes, please explain:

\_\_\_\_\_

Does your child have a Dentist? Yes \_\_\_ No \_\_\_ If so, when was your child last seen? \_\_\_\_\_

Does your child participate in any sports? Yes \_\_\_ No \_\_\_ Name of Sport: \_\_\_\_\_



### Insurance:

Health Insurance: \_\_\_\_\_ Policy Number \_\_\_\_\_

Policy Holder: \_\_\_\_\_ My child does not have health insurance \_\_\_\_\_

*I am the legal parent/guardian of the above named child and I give my consent for EECH to give my child a sports physical at school.*

*Further, if applicable, I give permission for EECH to mail referrals and/or prescriptions to the address provided above.*

**Print Parent/Guardian Name:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# Parental Consent Form

Estimados Padres/Guardianes,

El centro de salud Ellaine Ellis (EECH) esta proveendo Cuidado rutinario/Exámenes físicos en la escuela de su hijo. Si usted desea que su hijo participe, llene la siguiente informacion y adjunte también una copia de su tarjeta de identificación con foto para respaldar el consentimiento.

Nombre de Nino(a): \_\_\_\_\_

Fecha de nacimiento: \_\_\_\_\_ Edad: \_\_\_\_\_ Sexo: \_\_\_ M \_\_\_ F

Direccion: \_\_\_\_\_ Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Codigo Postal: \_\_\_\_\_

Numero de telefono: \_\_\_\_\_ Correo Electronico: \_\_\_\_\_

Tenemos permiso de llamarle? Si \_\_\_ No \_\_\_ Mandar mensaje de texto? Si \_\_\_ No \_\_\_ Mandar correo Electronico? Si \_\_\_ No \_\_\_

Que escuela atiende su hijo(a)? \_\_\_\_\_ Grado \_\_\_\_\_

### Additional Information

Quien es el doctor primario de su hijo(a)? \_\_\_\_\_

Esta su hijo tomando medicamentos? Si \_\_\_ No \_\_\_ Nombre de medicamentos? \_\_\_\_\_

Es su hijo alergico a algun medicamento(s)? Si \_\_\_ No \_\_\_ Reaccion: \_\_\_\_\_

Ha tenido su hijo algun problema medico en el pasado? Si \_\_\_ No \_\_\_ Sirujias? Yes \_\_\_ No \_\_\_

Si ha tenido sirujias por favor explique:

\_\_\_\_\_

Su hijo tiene Dentista? Si \_\_\_ No \_\_\_ Cuando fue la ultima visita dental? \_\_\_\_\_

Participa su hijo(A) en deportes? Si \_\_\_ No \_\_\_ Nombre del deporte: \_\_\_\_\_

### Seguro:

Seguro Medico: \_\_\_\_\_ Numero de Poliza: \_\_\_\_\_

Nombre en la poliza: \_\_\_\_\_ Mi hijo no tiene seguro

*Soy el guardia legal de el paciente escrito arriba y doy consentimiento a EECH que haga un examen fisico en la escuela.*

*Además, si corresponde, doy permiso a EECH para que envíe referencias y / o recetas a la dirección proporcionada anteriormente.*

Nombre de padre/Guardian: \_\_\_\_\_

Firma de padre/Guardian: \_\_\_\_\_ Fecha: \_\_\_\_\_



# Prince George's County Public Schools

## 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 *shall* be submitted if guardianship or insurance information changes.

My child, \_\_\_\_\_, has my permission to participate in the  
**First Name** **Last Name**

following Prince George's County athletic program for the \_\_\_\_\_ school year.

School \_\_\_\_\_ Sport \_\_\_\_\_

\_\_\_\_\_  
**Parents/Guardian Signatures**      **(Date)**      **Address**

\_\_\_\_\_  
**Home Phone**      **Work Phone**

## Request for Student Pre-Participation Physical Evaluation Form

It is extremely important that the school maintain a copy of your child's pre-participation evaluation form in the individual school record kept in the school health nurse's suite. Pre-participation forms are to be collected by the athletic director. The forms *shall* be kept in a secure file at all times.

Please sign and date if you agree to have your child's physical evaluation form on file.

\_\_\_\_\_  
**Parent or Guardian Signature**      **(Date)**

## Insurance Information

The school does not provide insurance coverage for athletes other than the group catastrophic policy for county football programs. All participants *shall* have their own insurance coverage in effect prior to participation to cover injuries that might arise.

My child has injury insurance coverage under policy # \_\_\_\_\_  
through \_\_\_\_\_  
**Insurance Company**

\_\_\_\_\_  
**Parent or 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) \_\_\_\_\_

## ■ EVALUACIÓN FÍSICA PREVIA A LA PARTICIPACIÓN

### FORMULARIO DE HISTORIAL CLÍNICO

Nota: Complete y firme este formulario (con la supervisión de sus padres si es menor de 18 años) antes de acudir a su cita.

Nombre: \_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_

Fecha del examen médico: \_\_\_\_\_ Deporte(s): \_\_\_\_\_

Sexo que se le asignó al nacer (F, M o intersexual): \_\_\_\_\_ ¿Con cuál género se identifica? (F, M u otro): \_\_\_\_\_

Mencione los padecimientos médicos pasados y actuales que haya tenido. \_\_\_\_\_

¿Alguna vez se le practicó una cirugía? Si la respuesta es afirmativa, haga una lista de todas sus cirugías previas. \_\_\_\_\_

Medicamentos y suplementos: Enumere todos los medicamentos recetados, medicamentos de venta libre y suplementos (herbolarios y nutricionales) que consume. \_\_\_\_\_

¿Sufre de algún tipo de alergia? Si la respuesta es afirmativa, haga una lista de todas sus alergias (por ejemplo, a algún medicamento, al polen, a los alimentos, a las picaduras de insectos). \_\_\_\_\_

#### Cuestionario sobre la salud del paciente versión 4 (PHQ-4)

Durante las últimas dos semanas, ¿con qué frecuencia experimentó alguno de los siguientes problemas de salud? (Encierre en un círculo la respuesta)

	Ningún día	Varios días	Más de la mitad de los días	Casi todos los días
Se siente nervioso, ansioso o inquieto	0	1	2	3
No es capaz de detener o controlar la preocupación	0	1	2	3
Siente poco interés o satisfacción por hacer cosas	0	1	2	3
Se siente triste, deprimido o desesperado	0	1	2	3

(Una suma  $\geq 3$  se considera positiva en cualquiera de las subescalas, [preguntas 1 y 2 o preguntas 3 y 4] a fin de obtener un diagnóstico).

PREGUNTAS GENERALES (Dé una explicación para las preguntas en las que contestó "Sí", en la parte final de este formulario. Encierre en un círculo las preguntas si no sabe la respuesta).			Sí	No
1.	¿Tiene alguna preocupación que le gustaría discutir con su proveedor de servicios médicos?			
2.	¿Alguna vez un proveedor de servicios médicos le prohibió o restringió practicar deportes por algún motivo?			
3.	¿Padece algún problema médico o enfermedad reciente?			
PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR			Sí	No
4.	¿Alguna vez se desmayó o estuvo a punto de desmayarse mientras hacía, o después de hacer, ejercicio?			

PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR (CONTINUACIÓN)		Sí	No
5.	¿Alguna vez sintió molestias, dolor, compresión o presión en el pecho mientras hacía ejercicio?		
6.	¿Alguna vez sintió que su corazón se aceleraba, palpitaba en su pecho o latía intermitentemente (con latidos irregulares) mientras hacía ejercicio?		
7.	¿Alguna vez un médico le dijo que tiene problemas cardíacos?		
8.	¿Alguna vez un médico le pidió que se hiciera un examen del corazón? Por ejemplo, electrocardiografía (ECG) o ecocardiografía.		
9.	Cuando hace ejercicio, ¿se siente mareado o siente que le falta el aire más que a sus amigos?		
10.	¿Alguna vez tuvo convulsiones?		

PREGUNTAS SOBRE LA SALUD CARDIOVASCULAR DE SU FAMILIA		
	Sí	No
11. ¿Alguno de los miembros de su familia o pariente murió debido a problemas cardíacos o tuvo una muerte súbita e inesperada o inexplicable antes de los 35 años de edad (incluyendo muerte por ahogamiento o un accidente automovilístico inexplicables)?		
12. ¿Alguno de los miembros de su familia padece un problema cardíaco genético como la miocardiopatía hipertrófica (HCM), el síndrome de Marfan, la miocardiopatía arritmogénica del ventrículo derecho (ARVC), el síndrome del QT largo (LQTS), el síndrome del QT corto (SQTS), el síndrome de Brugada o la taquicardia ventricular polimórfica catecolaminérgica (CPVT)?		
13. ¿Alguno de los miembros de su familia utilizó un marcapasos o se le implantó un desfibrilador antes de los 35 años?		
PREGUNTAS SOBRE LOS HUESOS Y LAS ARTICULACIONES		
	Sí	No
14. ¿Alguna vez sufrió una fractura por estrés o una lesión en un hueso, músculo, ligamento, articulación o tendón que le hizo faltar a una práctica o juego?		
15. ¿Sufre alguna lesión ósea, muscular, de los ligamentos o de las articulaciones que le causa molestia?		
PREGUNTAS SOBRE CONDICIONES MÉDICAS		
	Sí	No
16. ¿Tose, sibila o experimenta alguna dificultad para respirar durante o después de hacer ejercicio?		
17. ¿Le falta un riñón, un ojo, un testículo (en el caso de los hombres), el bazo o cualquier otro órgano?		
18. ¿Sufre dolor en la ingle o en los testículos, o tiene alguna protuberancia o hernia dolorosa en la zona inguinal?		
19. ¿Padece erupciones cutáneas recurrentes o que aparecen y desaparecen, incluyendo el herpes o Staphylococcus aureus resistente a la meticilina (MRSA)?		

PREGUNTAS SOBRE CONDICIONES MÉDICAS (CONTINUACIÓN)		
	Sí	No
20. ¿Alguna vez sufrió un traumatismo craneoencefálico o una lesión en la cabeza que le causó confusión, un dolor de cabeza prolongado o problemas de memoria?		
21. ¿Alguna vez sintió adormecimiento, hormigueo, debilidad en los brazos o piernas, o fue incapaz de mover los brazos o las piernas después de sufrir un golpe o una caída?		
22. ¿Alguna vez se enfermó al realizar ejercicio cuando hacía calor?		
23. ¿Usted o algún miembro de su familia tiene el rasgo drepanocítico o padece una enfermedad drepanocítica?		
24. ¿Alguna vez tuvo o tiene algún problema con sus ojos o su visión?		
25. ¿Le preocupa su peso?		
26. ¿Está tratando de bajar o subir de peso, o alguien le recomendó que baje o suba de peso?		
27. ¿Sigue alguna dieta especial o evita ciertos tipos o grupos de alimentos?		
28. ¿Alguna vez sufrió un desorden alimenticio?		
ÚNICAMENTE MUJERES		
	Sí	No
29. ¿Ha tenido al menos un periodo menstrual?		
30. ¿A los cuántos años tuvo su primer periodo menstrual?		
31. ¿Cuándo fue su periodo menstrual más reciente?		
32. ¿Cuántos periodos menstruales ha tenido en los últimos 12 meses?		

**Proporcione una explicación aquí para las preguntas en las que contestó "Sí".**

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**Por la presente declaro que, según mis conocimientos, mis respuestas a las preguntas de este formulario están completas y son correctas.**

Firma del atleta: \_\_\_\_\_

Firma del padre o tutor: \_\_\_\_\_

Fecha: \_\_\_\_\_

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_  
 \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Health Questionnaire Version 4 (PHQ-4)  
 Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)			Yes	No
1. Do you have any concerns that you would like to discuss with your provider?				
2. Has a provider ever denied or restricted your participation in sports for any reason?				
3. Do you have any ongoing medical issues or recent illness?				
HEART HEALTH QUESTIONS ABOUT YOU			Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?				
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?				
7. Has a doctor ever told you that you have any heart problems?				
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.				

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)			Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?				
10. Have you ever had a seizure?				
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY			Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?				
12. 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)?				
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?				

BONE AND JOINT QUESTIONS	Yes	No
14. 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?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

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I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

#### PHYSICIAN REMINDERS

- 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, e-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-enhancing 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>		

<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 as having 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.**

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**Please indicate whether you have ever had any of the following conditions:**

	Yes	No
Atlantoaxial instability		
Radiographic (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.**

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**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Medically eligible for all sports without restriction

Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

\_\_\_\_\_  
 Medically eligible for certain sports

\_\_\_\_\_  
 Not medically eligible pending further evaluation

Not medically eligible for any sports

Recommendations: \_\_\_\_\_

\_\_\_\_\_  
I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_

\_\_\_\_\_  
Medications: \_\_\_\_\_

\_\_\_\_\_  
Other information: \_\_\_\_\_

\_\_\_\_\_  
Emergency contacts: \_\_\_\_\_

**PRE-PARTICIPATION COVID-19  
Supplemental Questions for Student's Physical**

This form should be completed by the student's physician at the time of a physical.

**Student History**

1. Has your child or adolescent been diagnosed with COVID-19?  
Yes    No
  
2. Was your child or adolescent hospitalized as a result for complications of COVID-19?  
Yes    No
  
3. Has your Child been diagnosed with Multi-inflammatory Syndrome in Children?  
Yes    No
  
4. Has your child or adolescent had direct known exposure to someone diagnosed with COVID-19?  
Yes    No

**Please address any "yes" answers to the above questions here:**

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**COVID-19 Awareness**  
**Parent/Student-Athlete Participation Acknowledgement Statements**

I \_\_\_\_\_, the parent/guardian of \_\_\_\_\_, acknowledge that I have received information on all of the following:

- What you should know about COVID-19 to protect yourself and others
- Share facts about COVID-19
- Multisystem Inflammatory Syndrome in Children (MIS-C)
- COVID-19 Frequently Asked Questions from the Maryland State Health Department.  
<https://coronavirus.maryland.gov/#FAQ>

I \_\_\_\_\_, the parent/guardian of \_\_\_\_\_, will follow the requirements for in-person attendance at any extracurricular athletic and activity event.

- I will not send my child to extracurricular athletic and activities if they are exhibiting any signs/symptoms of COVID 19 or have been exposed to someone with COVID 19 (or presumed to have COVID 19) in the past 14 days.
- I will review symptoms with my child and monitor my child’s symptoms every day that my child attends in-person activities/events.
- If my child becomes ill during any in-person activity/event, I will ensure they are picked up promptly. I will follow-up with an authorized health care provider/health department and comply with recommended quarantine or isolation as directed. If my child is ill, I understand that a release to return to in-person activity from an authorized health care provider will be required.

**Signs and Symptoms of COVID-19:**

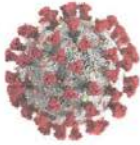
- |   |                              |
|---|------------------------------|
| • Fever (100.4°F or greater) or chills        | • Headache                   |
| • Cough                                       | • New loss of taste or smell |
| • Shortness of breath or difficulty breathing | • Sore throat                |
| • Fatigue                                     | • Congestion or runny nose   |
| • Muscle or body aches                        | • Nausea or vomiting         |
|   | • Diarrhea                   |

Students must be free of fever without the use of fever reducing medications.

**Parent/Guardian** \_\_\_\_\_ **Parent/Guardian** \_\_\_\_\_  
Print Name Signature and Date

**Student Athlete** \_\_\_\_\_ **Student Athlete** \_\_\_\_\_  
Print Name Signature and Date

# What you should know about COVID-19 to protect yourself and others



## Know about COVID-19

- Coronavirus (COVID-19) is an illness caused by a virus that can spread from person to person.
- The virus that causes COVID-19 is a new coronavirus that has spread throughout the world.
- COVID-19 symptoms can range from mild (or no symptoms) to severe illness.



## Know how COVID-19 is spread

- You can become infected by coming into close contact (about 6 feet or two arm lengths) with a person who has COVID-19. COVID-19 is primarily spread from person to person.
- You can become infected from respiratory droplets when an infected person coughs, sneezes, or talks.
- You may also be able to get it by touching a surface or object that has the virus on it, and then by touching your mouth, nose, or eyes.



## Protect yourself and others from COVID-19

- There is currently no vaccine to protect against COVID-19. The best way to protect yourself is to avoid being exposed to the virus that causes COVID-19.
- Stay home as much as possible and avoid close contact with others.
- Wear a cloth face covering that covers your nose and mouth in public settings.
- Clean and disinfect frequently touched surfaces.
- Wash your hands often with soap and water for at least 20 seconds, or use an alcohol-based hand sanitizer that contains at least 60% alcohol.



## Practice social distancing

- Buy groceries and medicine, go to the doctor, and complete banking activities online when possible.
- If you must go in person, stay at least 6 feet away from others and disinfect items you must touch.
- Get deliveries and takeout, and limit in-person contact as much as possible.



## Prevent the spread of COVID-19 if you are sick

- Stay home if you are sick, except to get medical care.
- Avoid public transportation, ride-sharing, or taxis.
- Separate yourself from other people and pets in your home.
- There is no specific treatment for COVID-19, but you can seek medical care to help relieve your symptoms.
- If you need medical attention, call ahead.



## Know your risk for severe illness

- Everyone is at risk of getting COVID-19.
- Older adults and people of any age who have serious underlying medical conditions may be at higher risk for more severe illness.



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[cdc.gov/coronavirus](https://cdc.gov/coronavirus)



