



# Somerset County Public Schools

Dr. John Gaddis  
Superintendent of Schools

7982A Tawes Campus Drive  
Westover, MD 21871  
[www.somerset.k12.md.us](http://www.somerset.k12.md.us)  
Telephone: 410.651.1616  
Instructional Fax: 410.651.2931  
Administrative Fax: 410.651.3566

Board Members  
William M. Miles, Chairperson  
Robert T. Wells, Vice Chairperson  
Margo Green-Gale  
Dan Kuebler  
BG Warner I. Sumpter USA (Ret.)

## INSURANCE REQUIREMENTS FOR STUDENTS PARTICIPATING IN SPORTS

The Board of Education requires that any student participating in sports be covered by an insurance plan that will offer benefits in the event of accidental injury. This requirement may be met by providing proof of parent's health insurance or by purchasing insurance offered through the school system.

Students who are unable to provide proof of insurance coverage will be required to enroll in the School Insurance Plan prior to participating in any sport.

Parents not wishing to enroll their child in the plan offered by the school system must complete the form below prior to the student being permitted to participate in sports. Please review your health insurance to assure proper protection for your child.

### PROOF OF INSURANCE PERMISSION SLIP

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Primary Insurance Coverage

Secondary Insurance Coverage

Insured's Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's SSN \_\_\_\_\_

Insured's SSN \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_

Claim Address \_\_\_\_\_

Claim Address \_\_\_\_\_

Ins. Phone # \_\_\_\_\_

Ins. Phone # \_\_\_\_\_

Policy # \_\_\_\_\_

Policy # \_\_\_\_\_

Plan \_\_\_\_\_

Plan \_\_\_\_\_

Group # \_\_\_\_\_

Group # \_\_\_\_\_

Type (HMO, PPO, etc.) \_\_\_\_\_

Type (HMO, PPO, etc.) \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION FOR STUDENT'S  
PARTICIPATION IN SPORTS

As parents or legal guardians of \_\_\_\_\_  
(Student's Name)

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 recognize that, even with proper training and equipment, there is always a risk of serious accidental injury or death inherent in interscholastic athletics and sports.

In consideration of the acceptance of our child by the Somerset County Public Schools in its athletic program, we agree to release and hold harmless the Board of Education of Somerset County, its members, the Superintendent of Schools, the Principal, all coaches, and assistant coaches, athletic trainers and any of their agents, servants, and/or employees and agree to indemnify each of them, from any and all 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 Somerset County and its agents, servants, athletic trainers and/or employee 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, and practice sessions, and during travel to and from athletic contests.

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

\_\_\_\_\_  
(Student's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(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 prosthesis?		
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

---



---



---



---

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

	Yes	No
Allantoaxial instability		
X-ray evaluation for allantoaxial 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

- 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14)

EXAMINATION		Male	Female
Height	Weight		
BP	Pulse	Vision R 20'	L 20'
		Corrected	Y N
<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	
Appearance <ul style="list-style-type: none"> <li>Murphy's sign (kyphoscoliosis, high-arched palate, pectus excavatum, arachnoid cyst, arm span &gt; height, hyperaxilia, myopia, MVP, aortic insufficiency)</li> </ul>			
Eyes/nose/throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>			
Lymph nodes			
Heart* <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>Location of point of maximal impulse (PMI)</li> </ul>			
Pulses <ul style="list-style-type: none"> <li>Simultaneous femoral and radial pulses</li> </ul>			
Lungs			
Abdomen			
Genitourinary (males only)**			
Skin <ul style="list-style-type: none"> <li>HSV, lesions suggestive of MRSA, linea corporis</li> </ul>			
Neurologic*			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/leg			
Knee			
Leg/ankle			
Foot/feet			
Functional <ul style="list-style-type: none"> <li>Shoe-walk, single leg hop</li> </ul>			

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

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

Recommendations \_\_\_\_\_

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

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Signature of physician \_\_\_\_\_ MD or DO

# ■ 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# HEADS\*UP

## CONCUSSION IN HIGH SCHOOL SPORTS

### A FACT SHEET FOR PARENTS

#### What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

#### What are the signs and symptoms?

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 after the injury. If your teen reports *one or more* symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

Signs Observed by Parents or Guardians	Symptoms Reported by Athlete
<ul style="list-style-type: none"> <li>• Appears dazed or stunned</li> <li>• Is confused about assignment or position</li> <li>• Forgets an instruction</li> <li>• Is unsure of game, score, or opponent</li> <li>• Moves clumsily</li> <li>• Answers questions slowly</li> <li>• Loses consciousness (even briefly)</li> <li>• Shows mood, behavior, or personality changes</li> <li>• Can't recall events prior to hit or fall</li> <li>• Can't recall events after hit or fall</li> </ul>	<ul style="list-style-type: none"> <li>• Headache or "pressure" in head</li> <li>• Nausea or vomiting</li> <li>• Balance problems or dizziness</li> <li>• Double or blurry vision</li> <li>• Sensitivity to light or noise</li> <li>• Feeling sluggish, hazy, foggy, or groggy</li> <li>• Concentration or memory problems</li> <li>• Confusion</li> <li>• Just not "feeling right" or is "feeling down"</li> </ul>

#### How can you help your teen prevent a concussion?

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.

- Ensure that they follow their coaches' rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

#### What should you do if you think your teen has a concussion?

1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Don't let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first—usually within a short period of time (hours, days, or weeks)—can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
3. **Teach your teen that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your teen convince you that s/he's "just fine."
4. **Tell all of your teen's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen's coaches, school nurse, and teachers. If needed, they can help adjust your teen's school activities during her/his recovery.

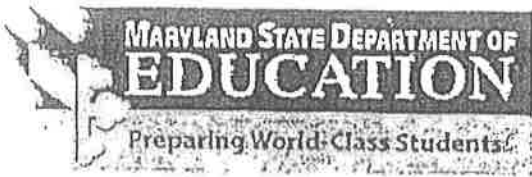
If you think your teen has a concussion:  
Don't assess it yourself. Take him/her out of play.  
Seek the advice of a health care professional.

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

For more information and to order additional materials free-of-charge, visit: [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion).

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION





For official use only:

Name of Athlete \_\_\_\_\_

Sport/season \_\_\_\_\_

Date Received \_\_\_\_\_

## Concussion Awareness Parent/Student-Athlete Acknowledgement Statement

I \_\_\_\_\_ the parent/guardian  
of \_\_\_\_\_ acknowledge that I 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 \_\_\_\_\_  
Print name Signature

Date \_\_\_\_\_

Student Athlete \_\_\_\_\_ Student Athlete \_\_\_\_\_  
Print name Signature

Date \_\_\_\_\_

**It's better to miss one game than the whole season!**

For more information visit: [www.cdc.gov/concussion](http://www.cdc.gov/concussion)