

POCOMOKE HIGH SCHOOL ATHLETIC PHYSICAL PACKET



2026-2027

MEDICAL CLEARANCE FOR SPORTS

Step 1 PARENTS SHOULD REGISTER THE ATHLETE
EACH SPORT SEASON AT:

www.familyid.com/pocomoke-high-school

Step 2 ATHLETIC PHYSICALS If you would like to schedule
an appointment for an athletic physical at the school-based
health center during the school year **CALL 410-430-8388**

Step 3 Submit **COMPLETED** Physical Packet to **ATHLETIC
TRAINER**

IMPORTANT DATE REMINDERS:

FALL SPORT REGISTRATION OPENS	4/1/26
PRACTICE BEGINS	8/12/26
WINTER SPORT REGISTRATION OPENS	9/1/26
SPRING SPORT REGISTRATION OPENS	12/1/26



MARYLAND PUBLIC SECONDARY SCHOOL ATHLETIC ASSOCIATION (MPSSAA)

Recommended Preparticipation Physical Form

MPSSAA Medical Advisory Committee

Student Athlete and Parent/Guardian Check list for Sports Registration

- _____ 1. Please make sure to read all information that your school provides about Eligibility, Expectations, Tryouts, Practice & Game Schedules, Transportation (to and from games), Login to the School System Registration website.

- _____ 2. Page 2: Health History form. This is filled out by the student athlete & parent/guardian. Please fill out the Student Athlete Health History form, take it to the Pre-participation Physical Exam (PPE) appointment and review with the Healthcare Professional. Make sure to clarify/explain any questions that you have answered "YES". Please keep a copy to turn into the school.

- _____ 3. Page 3: Pre-participation Physical Exam (PPE). This will be completed by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Certified Registered Nurse Practitioner (CRNP) or Physician Assistant – Certified (PA-C) only.
Pre-participation Physical may not be completed/signed by a parent/guardian even if they are a licensed healthcare professional.
 - Before leaving the appointment, please make sure the following have been completed:
 - _____ The Healthcare provider signed, dated, and stamped the PPE.
 - _____ The Healthcare provider has checked off the appropriate participation in athletics box.
 - _____ You have both the Health History form and Pre-participation, Physical Exam (PPE) form. (you will need to provide both forms to the school during sports registration)

- _____ 4. Page 4: Emergency Information Form (to be completed and signed by parent/guardian). This information will be shared with the coach(es) in case of an emergency at practice/game.

- _____ 5. Students who require medication at school (including during school team practices or games) must have a doctor's order on file with the school's nurse for each medicine. Please visit this link and take this form to your Healthcare provider for school medication administration authorization. (This needs to be completed each year) [School Medication Administration Authorization Form \(marylandpublicschools.org\)](http://marylandpublicschools.org)

The information provided on the Health History and Pre-Participation Physical is considered confidential medical records, it is established and maintained for every student. The confidentiality of a student's medical records information is protected under the federal Family Education Rights and Privacy Act (FERPA), Maryland state law and/or the local school system policy, as applicable.

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.

Completion of the Preparticipation Physical is a requirement for student-athlete participation in interscholastic athletics. Falsifying information, forging signatures, or misrepresentation of a student's physical fitness compromises the health and safety of the student and may lead to penalties assessed by the local educational agency, including potential determination of ineligibility.

PART II- MEDICAL HISTORY (Explain "YES" answers below) Name:**Grade:**

This form must be completed and signed, prior to the physical examination, for review by examining practitioner.

Explain "YES" answers below with number of the question. Circle questions you don't know the answers to.

GENERAL MEDICAL HISTORY		YES	NO	MEDICAL QUESTIONS CONTINUED		YES	NO
1. Do you have any concerns you want to discuss with your provider?				24. Have you had mononucleosis (mono) within the last month?			
2. Has a provider ever denied or restricted your participation in sports for any reason?				25. Are you missing a kidney, eye, testicle, spleen or other internal organ?			
3. Do you have any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections. Other: _____				26. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			
4. Are you taking any medications or supplements daily?				27. Have you ever become ill while exercising in the heat?			
5. Do you have allergies to any medications?				28. When exercising in the heat, do you have severe muscle cramps?			
6. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?				29. Do you have headaches from exercise?			
7. Have you ever spent the night in the hospital? If yes, why? _____				30. Have you ever had numbness, tingling or weakness in your arms or legs or been unable to move your arms or legs AFTER being hit or falling?			
8. Have you ever had surgery?				31. Do you have sickle cell trait or disease? Does someone in your family have sickle cell trait or disease?			
HEART HEALTH QUESTIONS ABOUT YOU				32. Have you had any other blood disorders?			
9. Have you ever passed out or nearly passed out DURING or AFTER exercise?				33. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?			
10. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				34. Have you had or do you have any problems with your eyes or vision?			
11. Does your heart race, flutter in your chest or skip beats (irregular beats) during exercise?				35. Do you wear glasses or contacts?			
12. Has a doctor ever ordered a test for your heart? For example, electrocardiography or echocardiography.				36. Do you wear protective eyewear like goggles or a face shield?			
13. Has a doctor ever told you that you have any heart problems, including: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki Disease ☐ Other _____				37. Do you worry about your weight?			
				38. Have you ever been diagnosed with an eating disorder?			
				39. Are you on a special diet or do you avoid certain types of foods or food groups?			
				40. Allergies to food or stinging insects?			
				41. Have you ever had a COVID-19 diagnosis? Date: _____			
				42. What is the date of your last Tdap or Td (tetanus) immunization? (circle type) Date: _____			
14. Do you get light-headed or feel shorter of breath than your friends during exercise?				FEMALES ONLY			
15. Have you ever had a seizure?				45. Have you ever had a menstrual period?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY				46. Age when you had your first menstrual period: _____			
16. Does anyone in your family have a heart problem?				47. Number of periods in the last 12 months: _____			
17. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning or unexplained car crash)?				48. When was your most recent menstrual period? _____			
18. 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)?				EXPLAIN "YES" ANSWERS BELOW list the number you are clarifying/explaining			
				• _____			
				• _____			
				• _____			
				• _____			
				• _____			
19. Has anyone in your family had a pacemaker or an implanted defibrillator before age 50?				• _____			
BONE AND JOINT QUESTIONS				List medications and nutritional supplements you are currently taking here:			
20. 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?				• _____			
21. Do you currently have a bone, muscle, or joint injury that bothers you?				• _____			
MEDICAL QUESTIONS							
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?							
23. Do you have asthma or use asthma medicine (inhaler, nebulizer)?							

→ Parent/Guardian Signature: _____ Date: _____ → Athlete's Signature: _____

PART III- PHYSICAL EXAMINATION

(Pre-participation Physical may not be completed/signed by a parent/guardian even if a licensed healthcare professional)

NAME _____		DATE OF BIRTH _____		SCHOOL _____	
Height _____		Weight _____		Sex Assigned at Birth _____	
BP /	RR	Resting pulse	Vision	R 20/	L 20/
Corrected ☐ Yes ☐ No					
Pediatric Population > 13 years and older within normal limits =		BP (F) 102-121/64-79 mmHg		BP (M) 102-124/64-80 mmHg	
		RR 12-20 breaths per minute		Pulse 55-90 bpm	
MEDICAL			NORMAL	ABNORMAL FINDINGS	
Appearance (Marfan stigmata: kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse, and aortic insufficiency)					
Eyes/ears/nose/throat (Pupils equal, hearing)					
Neck - Lymph nodes, thyroid enlargement					
Heart (Murmurs: auscultation standing, supine, +/- Valsalva)					
Pulses (radial, femoral, pedal)					
Lungs					
Abdomen					
Skin (Herpes simplex virus, lesions suggestive of MRSA or tinea corporis)					
Neurologic (cranial nerve and gait)					
MUSCULOSKELETAL			NORMAL	ABNORMAL FINDINGS	
Neck					
Back					
Shoulder/arm					
Elbow/forearm					
Wrist/hand/fingers					
Hip/thigh					
Knee					
Leg/ankle					
Foot/toes					
Functional (i.e. Double leg squat, single leg squat, box drop, or step drop test)					
Consider ECG, Echocardiogram, and referral to cardiology if abnormal cardiac history/exam or family history to address Sudden Cardiac Arrest & Sudden Cardiac Death risk.					
Consider cognitive evaluation or baseline neuropsychiatric testing if history of significant prior to concussion.					
Emergency medications required on-site: ☐ Inhaler ☐ Epinephrine ☐ Glucagon ☐ Other: _____					
COMMENTS: _____					

I have reviewed the data above, reviewed the student's medical history form and make the following commendations for the students' participation in athletics:

☐ Healthcare Professional completed and reviewed a Mental Health Screening with the athlete.

☐ MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION

☐ MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATION FOR FURTHER EVALUATION OR TREATMENT OF:

☐ MEDICALLY ELIGIBLE ONLY FOR THE FOLLOWING SPORTS: _____

Reason: _____

☐ NOT MEDICALLY ELIGIBLE FOR ANY SPORTS

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Medical History.

→ PRACTITIONER SIGNATURE: _____ (MD, DO, NP or PA) + DATE**: _____

EXAMINER'S NAME AND DEGREE (PRINT): _____ PHONE NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Physician Office Stamp:

+Only signature of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted.

PART IV- EMERGENCY INFORMATION FORM* (To be completed and signed by the parent/guardian)**Please Print**

STUDENT'S NAME: _____ GRADE: _____ AGE: _____ DOB: _____

SPORT(S): _____

Please list any significant health problems that might be significant to a physician evaluating your child in case of an emergency:

PLEASE LIST ANY ALLERGIES TO MEDICATIONS, ETC:

IS THE STUDENT CURRENTLY PRESCRIBED AN INHALER? (circle only one) YES NO

IS THE STUDENT CURRENTLY PRESCRIBED AN EPI PEN? (circle one one) YES NO

Primary Contact Name: _____ Relationship to student: _____

DAYTIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

EVENING PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

CELL PHONE NUMBER: _____

Secondary Contact Name: _____ Relationship to student: _____

DAYTIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

EVENING PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

CELL PHONE NUMBER: _____

→ I CERTIFY ALL OF THE ABOVE INFORMATION IS CORRECT: _____

Parent/Guardian signature

Date: _____ PARENT/GUARDAIN NAME (PLEASE PRINT) _____

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.

**Maryland State Department of Education
Office of Child Care
Medication Administration Authorization Form**

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. **This authorization is NOT TO EXCEED 1 YEAR.**
This form is required for both prescription and non-prescription/over-the-counter (OTC) medications. Prescription medication must be in a container labeled by the pharmacist or prescriber.
Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

Place Child's
Picture Here
(optional)

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: ____/____/____

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from: ____/____/____ to ____/____/____

If PRN, for what symptoms, how often and how long _____

Possible side effects and special instructions: _____

Known Food or Drug Allergies: ☐ Yes ☐ No If yes, please explain: _____

For School Age children only: The child may self-carry this medication: ☐ Yes ☐ No

The child may self-administer this medication: ☐ Yes ☐ No

PRESCRIBER'S NAME/TITLE

Place Stamp Here (Optional)

TELEPHONE

FAX

ADDRESS

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only), DATE (mm/dd/yyyy),

PARENT/GUARDIAN AUTHORIZATION

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer** ☐ Yes ☐ No

PARENT/GUARDIAN SIGNATURE

DATE (mm/dd/yyyy)

INDIVIDUALS AUTHORIZED TO PICK UP
MEDICATION

CELL PHONE #

HOME PHONE #

WORK PHONE #

CHILD CARE STAFF USE ONLY

Child Care Responsibilities:

1. Medication named above was received. Expiration date ____	☐ Yes ☐ No
2. Medication labeled as required by COMAR.	☐ Yes ☐ No
3. OCC 1214 Emergency Form updated.	☐ Yes ☐ No ☐ N/A
4. OCC 1215 Health Inventory updated.	☐ Yes ☐ No ☐ N/A
5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP.	☐ Yes ☐ No ☐ N/A
6. Staff approved to administer medication is available onsite, field trips	☐ Yes ☐ No

Reviewed by (printed name and signature):

DATE (mm/dd/yyyy)

MEDICATION ADMINISTRATION LOG

[illegible]