DO NOT FOLD FORM

MISSISSIPPI ATHLETIC PARTICIPATION FORM

ATHLETIC HEALTH HISTORY

Please Print

Name _____ Date _____
School _____ Grade _____ Sport(s) _____
Sex: M F Date of Birth _____ S.S.N. _____-_____-_____ Age _____
Address _____ Home Phone _____
Family Physician _____ Work Phone _____
Parent / Guardian Name _____ Work Phone _____

FAMILY MEDICAL HISTORY

Has any member of your family under age 50 had these conditions?

Yes	No	Condition	Whom
☐	☐	Heart Attack	_____
☐	☐	Sudden Death	_____
☐	☐	Stroke	_____
☐	☐	Heart Disease / High Pressure	_____
☐	☐	Diabetes	_____
☐	☐	Sickle Cell Anemia	_____
☐	☐	Arthritis	_____
☐	☐	Epilepsy	_____
☐	☐	Kidney Disease	_____

ATHLETE'S ORTHOPAEDIC HISTORY

Has the athlete had any of the following injuries?

Yes	No	Condition	Date	Yes	No	Condition	Date
☐	☐	Head Injury / Concussion	_____	☐	☐	Neck Injury / Stinger	_____
☐	☐	Shoulder L / R	_____	☐	☐	Arm / Wrist / Hand L / R	_____
☐	☐	Elbow L / R	_____	☐	☐	Back	_____
☐	☐	Hip	_____	☐	☐	Thigh L / R	_____
☐	☐	Knee L / R	_____	☐	☐	Lower Leg L / R	_____
☐	☐	Chronic Shin Splints	_____	☐	☐	Ankle L / R	_____
☐	☐	Foot L / R	_____	☐	☐	Severe Muscle Strain	_____
☐	☐	Pinched Nerve	_____	☐	☐	Chest	_____

Previous Surgeries: _____

ATHLETE'S MEDICAL HISTORY

Has the athlete had any of these conditions?

Yes	No	Condition			Condition			Condition
☐	☐	Heart Murmur	☐	☐	Organ Loss	☐	☐	Overnight in hospital
☐	☐	Seizures	☐	☐	Shortness of breath / coughing during exercise	☐	☐	Hernia
☐	☐	Kidney Disease	☐	☐	Knocked out	☐	☐	Rapid weight loss / gain
☐	☐	Irregular Pulse	☐	☐	Heart Disease	☐	☐	Take supplements / vitamins
☐	☐	Single Testicle	☐	☐	Diabetes	☐	☐	Heat related problems
☐	☐	High Blood Pressure	☐	☐	Liver Disease	☐	☐	Menstrual irregularities
☐	☐	Dizzy / Fainting	☐	☐	Tuberculosis	☐	☐	Recent Mononucleosis / Enlarged Spleen
☐	☐	Surgery - What Type? _____						
☐	☐	Allergies (Food, Drugs) _____						

Date of last Tetanus Immunization _____

To the best of our knowledge, we have given true and accurate information and we hereby grant permission for the physical screening evaluation. We understand the evaluation involves a limited examination and the screening is not intended to nor will it prevent injury or sudden death. We further understand that the examination will be provided without expectation of payment and that the physician and many other medical professionals providing services may be immune from liability under Mississippi law.

WAIVER FORM

This waiver, executed this _____ day of _____, 200_____, by FILL IN AT TIME OF PHYSICAL, M.D., and _____, patient, is executed in compliance with Mississippi law, with the full understanding that if a physician voluntarily provides needed medical or health services to any program at an accredited school in the state without expectation of payment, the physician will be immune from liability for any civil action arising out of the provision of those medical and/or health care services which were provided in good faith on a charitable basis. Such immunity does not extend to willful acts or gross negligence.

_____ _____
Typed or Printed Name of Patient — Signature of Patient or Patient's Parent or Guardian *(If Patient is 17 or younger)*

Information below to be filled out by physician only

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Orthopaedic Exam

		Norm	Abnl
I.	Spine / Neck	_____	_____
	Cervical	_____	_____
	Thoracic	_____	_____
	Lumbar	_____	_____
II.	Upper Extremity	_____	_____
	Shoulder	_____	_____
	Elbow	_____	_____
	Wrist	_____	_____
	Hand / Fingers	_____	_____
III.	Lower Extremity	_____	_____
	Hip	_____	_____
	Knee	_____	_____
	Ankle	_____	_____
	Feet	_____	_____

General Medical Exam

	Norm	Abnl		Norm	Abnl
ENT	_____	_____	Lungs	_____	_____
Heart	_____	_____	Abdomen	_____	_____
Skin	_____	_____	Hernia (if Needed)	_____	_____

General Health Comments _____

FLEXIBILITY	LEFT	RIGHT	FLEXIBILITY	LEFT	RIGHT
Neck	_____	_____	Shoulder	_____	_____
Hips	_____	_____	Quads	_____	_____
Hams	_____	_____	Heelcords	_____	_____
Back Ext / Flex	_____	_____			

Comments _____

Other Comments _____

OPTIONAL EXAMS

DENTAL

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Comments _____

VISION L_____ R_____
Comments: _____

[ ] From this limited screening I see no reason why this student cannot participate in athletics
[[Student needs further evaluation as described

_____ _____**, M.D.**
Typed or Printed Name of Physician — **Signature of Physician**

PHYSICIAN - WHITE SCHOOL - CANARY PARENT/GUARDIAN - PINK

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