MISSISSIPPI ATHLETIC PARTICIPATION FORM

PLEASE PRINT

228-385-9000

NOTES

Name _____ Date _____

School _____ Grade _____ Sport(s) _____

Sex: M F Date of Birth _____ 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	Yes	No	Condition	Whom
☐	☐	Heart Attack		☐	☐	Diabetes	
☐	☐	Sudden Death		☐	☐	Sickle Cell Anemia	
☐	☐	Stroke		☐	☐	Arthritis	
☐	☐	Heart Disease/ High Pressure		☐	☐	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 this athlete had any of these conditions?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Heart Murmur	☐	☐	Shortness of breath / coughing during exercise	☐	☐	Hernia
☐	☐	Seizures	☐	☐	Knocked out	☐	☐	Rapid Weight loss / gain
☐	☐	Kidney Disease	☐	☐	Heart Disease	☐	☐	Take supplements / vitamins
☐	☐	Irregular Pulse	☐	☐	Diabetes	☐	☐	Head related problems
☐	☐	Single Testicle	☐	☐	Liver Disease	☐	☐	Menstrual irregularities
☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Recent Mononucleosis / Enlarged Spleen
☐	☐	Dizzy / Fainting	☐	☐	Overnight in hospital			
☐	☐	Organ Loss						

☐ ☐ Surgery - What Type? _____

☐ ☐ Allergies - (Food, Drugs) _____

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 _____, 20 __, by _____, 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 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: _____

VISION EXAM L _____ R _____ Comments: _____

☐ From this limited screening I see no reason why this student cannot participate in athletics
☐ Student needs further evaluation as described
☐ I see no reason why the student cannot participate after completion of the following: _____

TYPE OR PRINTED NAME OF PHYSICIAN

SIGNATURE OF PHYSICIAN

OOL - WHITE SPORTS MEDICINE - CANARY

DO NOT FOLD OR ROLL FORM

PARENT

DOCTOR