Hancock Middle/High School Athletic Department

7084 Stennis Airport Drive
Kiln, MS 39556
School Phone/Fax: (228)467-2251/467-2689 Athletic Phone/Fax: (228)467-2972/467-7397

2017/2018 Athletic Participation Consent Form

Student Data

Student's Full Legal Name:_____
(Last Name) (First Name) (M.I.)
Parent/Guardian Name:_____
(Last Name) (First Name) (M.I.)

Student's Social Security #:_____ **Student's Current Grade Level:**_____
Student's Date of Birth:_____ **Year Entered 7th/9th Grade:**_____
Street Address:_____ **Home Phone #:**_____

Parent Consent

I hereby give full consent for my above named child to participate in any and all required activities pertaining to the following sport/activity in the Hancock County School District's Athletic Department. I understand that by granting this permission I am agreeing to abide by all policies and rules set forth by the MHSAA, Hancock County School District, and the coach(es) of the program indicated below. I also understand and agree that all decisions regarding the participation of my child in this program are made by the coach(es) of this program.

***(Check all that apply)**

FALL	WINTER	SPRING
____ H.S. FOOTBALL	____H.S. BOY'S BASKETBALL	____H.S. BASEBALL
____ M.S. FOOTBALL	____H.S.GIRL'S BASKETBALL	____M.S.BASEBALL
____ VOLLEYBALL	____M.S. BOY'S BASKETBALL	____FAST PITCH SOFTBALL
____ H.S. CHEERLEADING	____M.S. GIRL'S BASKETBALL	____H.S. BOY'S TRACK
____ M.S. CHEERLEADING	____BOY'S SOCCER	____H.S. GIRL'S TRACK
____ SWIMMING	____GIRL'S SOCCER	____ M.S. BOY'S TRACK
____ CROSS COUNTRY	____WEIGHT LIFTING	____M.S. GIRL'S TRACK
____ M.S. VOLLEYBALL	____ BOWLING	____TENNIS
		____GOLF
		____ ARCHERY

Insurance/Medical Waiver

I, the above named parent/legal guardian, assume any expenses for liability not covered by the below indicated insurance coverage. I also accept full responsibility for all medical and other related expenses. I hereby waive the Hancock County School district, the Board of Education of the Hancock County School District, their agents of assigns, of responsibility for such injury or expenses and waive any and all claims which may arise against them. I realize that participating in organized interscholastic activities involves the potential for injury which is inherent in sports, sometimes severe enough to result in disability or death. The Hancock County School District, acting for students of the athletic program, makes available an athletic injury benefit plan through the school insurance. The purpose of this coverage is to supplement and assist in the cost of treatment of accidental injury. I hereby acknowledge that health and accident insurance coverage is required for participation in all organized athletic activities and further certify that my child is covered under the health and accident insurance program listed below. (CHECK ONE)

_____ **Student Insurance** _____**Self Insurance**(Copy Required)

Student Signature_____ **Date**_____

Parent Signature_____ **Date**_____

Superintendent: Alan Dedeaux **High School Principal: Tara Ladner**
Athletic Director: Jamie Sisco **Middle School Principal: Jessica Taylor**

HANCOCK medical
Hancock Medical Health Services, Inc.
149 Drinkwater Boulevard
Bay St. Louis, MS 39520
(228) 467-8600

PRE-PARTICIPATION HISTORY FORM

⇩ COMPLETE ENTIRE FORM & SIGN ⇩

Name: _____ Sex: ☐ M ☐ F Date of Birth: _____ Age: _____
Grade: _____ School: _____ Sport(s): _____
Address: _____ Phone: _____
Personal Physician: _____ Date of Last Exam: _____
Allergies: _____ Medication List: _____
In Case of Emergency, Contact: Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Answer all questions that apply by checking Yes or No

	YES	NO		YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?			24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have an ongoing medical condition (like diabetes or asthma)?			25. Is there anyone in your family who has asthma?		
3. Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?			26. Have you ever used an inhaler or taken asthma medicine?		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?			27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
5. Have you ever passed out or nearly passed out DURING exercise?			28. Have you had infectious mononucleosis (mono) within the last 6 weeks?		
6. Have you ever passed out or nearly passed out AFTER exercise?			29. Do you have any rashes, pressure sores, or other skin problems?		
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?			30. Have you had a herpes skin infection?		
8. Does your heart race or skip beats during exercise?			31. Have you ever had a head injury or concussion?		
9. Has a doctor ever told you that you have (check all that apply) ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection			32. Have you been hit in the head and been confused or lost your memory?		
10. Has a doctor ever ordered a test for your heart? (example: ECG, echocardiogram)			33. Have you ever had a seizure?		
11. Has anyone in your family died for no apparent reason?			34. Do you have headaches with exercise?		
12. Does anyone in your family have a heart problem?			35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or of sudden death before age 50?			36. Have you ever been unable to move your arms or legs after being hit or falling?		
14. Does anyone in your family have Marfan syndrome?			37. When exercising in the heat, do you have severe muscle cramps or become ill?		
15. Have you ever spent the night in a hospital?			38. Has a doctor told you that you or someone in your family has sickle cell disease?		
16. Have you ever had surgery?			39. Have you had any problems with your eyes or vision?		
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, which caused you to miss a practice or game? If yes, circle affected area below:			40. Do you wear glasses or contact lenses?		
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:			41. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: Head Neck Shoulder Upper Arm Elbow Forearm Hand/ Fingers Chest Upper Back Lower Back Hip Thigh Knee Calf/ Shin Ankle Foot/ Toes			42. Are you happy with your weight?		
			43. Are you trying to gain or lose weight?		
			44. Has anyone recommended you change your weight or eating habits?		
			45. Do you limit or carefully control what you eat?		
			46. Do you have any concerns that you would like to discuss with a doctor?		
			FEMALES ONLY:		
20. Have you ever had a stress fracture?			47. Have you ever had a menstrual period?		
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?			48. How old were you when you had your first menstrual period?		
22. Do you regularly use a brace or assistive device?			49. How many periods have you had in the last 12 months?		
23. Has a doctor ever told you that you have asthma or allergies?			50. Are you, or could you possibly be, pregnant?		

Explain "Yes" answers here: _____

To the best of my knowledge, I have given true and accurate information and I have answered all questions completely. I understand this evaluation involves a limited examination and the screening is not intended to nor will it prevent injury or sudden death. I hereby grant permission for this physical screening evaluation and I understand no evaluation will be done unless all questions are answered and this form is signed.

Printed Name of Parent/Guardian

Signature of Patient's Parent/Guardian
(Required if Patient Less Than 18 Years Old)

Date

HANCOCK medical
Hancock Medical Health Services, Inc.
149 Drinkwater Boulevard
Bay St. Louis, MS 39520
(228) 467-8600

PRE-PARTICIPATION PHYSICAL FORM

⇩ COMPLETE TOP TWO LINES ONLY ⇩

Name: _____ Sex: ☐ M ☐ F Date of Birth: _____ Age: _____

Grade: _____ School: _____ Sport(s): _____

Height: _____ Weight: _____ Vision: *R* 20/____ *L* 20/____ Corrected ☐ Y ☐ N

Pulse: _____ BP: _____/_____ (If > 140/90 Re-Check: _____/_____ & _____/_____)

Tobacco: ☐ Y ☐ N _____ ETOH: ☐ Y ☐ N _____ Drugs: ☐ Y ☐ N _____

☐ History Form Received & Reviewed

MEDICAL EXAM	NORMAL	ABNORMAL FINDINGS	DEFERRED
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Murmurs	Absent	Grade:	
Pulses			
Lungs			
Abdomen			
Genitourinary (Males Only)			
Skin			

MUSCULOSKELETAL EXAM	NORMAL	ABNORMAL FINDINGS	INITIALS
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Consider further evaluation if arm span greater than height, pectus excavtum or pectus carvatum is present.

Clearance Status: **Evaluation Not Done Due To:**

_____ Cleared to Participate

_____ Cleared After Follow-up Physician for _____
Clearance letter from physician follow up should be attached to this form.

_____ Cleared After Follow-up School Nurse for _____
School nurse should document follow up clearance and co-sign accordingly.

_____ Not Cleared for Following Reason(s): _____

_____ Incomplete Pre-Participation History Form

_____ Incomplete Parent/Guardian Signature

Additional Clearance Notes:

_____

_____

Additional Notes/Comments: _____

_____ _____
Provider Signature Date

HANCOCK HIGH SCHOOL ATHLETIC/EXTRACURRICULAR DEPARTMENT
7084 STENNIS AIRPORT RD.
KILN, MS 39556
SCHOOL PHONE/FAX: (228) 467-2251/467-2689 ATHLETIC PHONE/FAX: (228) 467-2972/467-7397

Exhibit A to Drug Testing Policy
General Authorization Form

Student Athletic I.D. Number – Assigned by Athletic Department

Student's Full Legal Name:_____
(Last Name) (First Name) (M.I.)

Parent/Guardian Name:_____
(Last Name) (First Name) (M.I.)

Student's Social Security #:_____ Student's Current Grade Level:____
Student's Date of Birth: _____
Address_____
Home Phone #:_____ Sports/Activity participating in:_____

I understand that my performance as a participant and the reputation of my school are dependent, in part, on my conduct as an individual. I hereby agree to accept and abide by the standards, rules, and regulations set forth by the Hancock County School District Board and the coaches/directors for the activities in which I participate.

I also authorize the Hancock County School District to conduct a test on a urine/hair specimen which I provide to test for drugs and/or alcohol use.

I also authorize the school district to provide transportation to and from the testing site by means of an authorized school district vehicle and to not hold the school or anyone acting on its behalf driving such a vehicle responsible for any injuries occurring in the course of such transportation.

I also authorize the release of information concerning the results of such a test to the Hancock County School District and to the parents and/or guardians of the student.

This shall be deemed a consent pursuant to the Family Education Right to Privacy Act for the release of the above information to the parties named above.

_____ _____
(Parent/Legal Guardian Signature) (Date)

_____ _____
(Student Signature) (Date)

_____ _____
(School Employee Signature) (Date)

Superintendent: Alan Dedeaux
Athletic Director: Jamie Sisco

High School Principal: Tara Ladner
Middle School Principal: Jessica Taylor

Hancock County School District
Athletic Department
Emergency Medical Authorization Form

This form must be made available by the coach at all team practices and contents to ensure proper medical treatment by physicians or hospital in the event of serious injury for each team member.

Athlete's Name: _____

Birth Date: _____ Grade: _____ Sex: _____

Parent/Guardian Name: _____

Home Phone: _____ Work Phone: _____

Address: _____ Zip: _____

In the event the parent or guardian cannot be contacted, please contact:

Name: _____ Phone Number: _____

List sports in which the above named athlete participates.

1. _____ 2. _____ 3. _____ 4. _____

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from his/her participation in athletics.

Preferred Physician: _____ Phone Number: _____

Preferred Hospital: _____

I understand this authorization will only be enforced if I cannot personally be contacted and provide for immediate treatment.

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ Date: _____

MISSISSIPPI HIGH SCHOOL ACTIVITIES ASSOCIATION, INC.

Concussion Information Form

(Required by MHSAA Annually)

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly**. In other words, even a "ding" or a bump on the head can be serious. You cannot see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

- Headaches
- "Pressure in head"
- Nausea or vomiting
- Neck pain
- Balance problems or dizziness
- Blurred, double or fuzzy vision
- Sensitivity to light or noise
- Feeling sluggish or slowed down
- Feeling foggy or groggy
- Drowsiness
- Change in sleep patterns
- Amnesia
- "Don't feel right"
- Fatigue or low energy
- Sadness
- Nervousness or anxiety
- Irritability
- More emotional
- Confusion
- Concentration or memory problems (forgetting game plays)
- Repeating the same question/comment

Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays incoordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can't recall events prior to hit
- Can't recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

(Continued on next page)

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the athlete especially

vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is key to a student-athlete's safety.

MHSAA Concussion Policy:

- An athlete who reports or displays any symptoms or signs of a concussion in a practice or game setting should be removed immediately from the practice or game. The athlete should not be allowed to return to the practice or game for the remainder of the day regardless of whether the athlete appears or states that he/she is normal.
- The athlete should be evaluated by a licensed, qualified medical professional working within their scope of practice as soon as can be practically arranged.
- If an athlete has sustained a concussion, the athlete should be referred to a licensed physician preferably one with experience in managing sports concussion injuries.
- The athlete who has been diagnosed with a concussion should be returned to play only after full recovery and clearance by a physician. Recovery from a concussion, regardless of loss on consciousness, usually take 7-14 days after resolution of all symptoms.
- Return to play after a concussion should be gradual and follow a progressive return to competition. An athlete should not return to a competitive game before demonstrating that he/she has no symptoms in a full supervised practice.
- Athletes should not continue to practice or return to play while still having symptoms of a concussion. Sustaining an impact to the head while recovering from a concussion may cause Second Impact Syndrome, a catastrophic neurological brain injury.

Remember, it is better to miss one game than to miss the whole season.

I have reviewed this information on concussions and am aware that a release by a medical doctor is required before a student may return to play under this policy.

Student-Athlete Name Printed	Student-Athlete Signature	Date
Parent Name Printed	Parent Signature	Date