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 | Yes | No | Condition | Yes | No | 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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# ATHLETIC PARTICIPATION CLEARANCE FORM

**MISSISSIPPI HIGH SCHOOL ACTIVITIES ASSOCIATION, INC.**
**P. O. BOX 127,CLINTON, MISSISSIPPI 39060**
**FAX – 601-924-1725**

I hereby give consent for my child, _____, to participate in the GULFPORT School District's athletic program during the _____ school year.

I agree to abide by the rules and regulations of my school district and its governing body, the Mississippi High School Activities Association.

I hereby authorize and give permission for emergency medical treatment to be rendered for and on behalf of my child, _____, for any injury received while participating in any supervised school related sports activity. This authorization includes, but is not limited to, any treatment deemed necessary by certified personnel, physicians, hospital emergency room physicians and hospitals.

I hereby release the GULFPORT School District and all school personnel for any and all liability associated with such necessary treatment.

I hereby acknowledge that health and accident insurance is recommended for participation in all organized athletic activities and further certify that my child is covered under the health and accident program listed below.

School day insurance: _____

Policy #: _____

Other insurance: _____

Policy #: _____

Name of agent: _____

The GULFPORT School District does not pay any expense incurred for any accident involving a student on school property or participating in school activities and does not provide health or accident insurance for participants in athletic programs.

In addition, I assume any expenses for liability not covered by the above required insurance policy for injury received by the above named student while participating in sports and activities. I accept full responsibility for medical and hospital expenses and any other related expenses and do hereby hold harmless the GULFPORT School District and the Board of Trustees, their agents or assignees, of responsibility for any such injury or expenses and waive any and all claims which may arise against them. I realize that participation in organized sports and activities involves the potential for injury, sometimes severe enough to result in total disability, paralysis, or death.

I give the Mississippi High School Activities Association and its assigns, licensees and legal representatives the irrevocable right to use any picture or image or sound recording of the student in all forms and media and in all manners, for any lawful purposes. In addition, I consent to the disclosure, by my child's/ward's school, to the MHSAA, upon its request, of all records relevant to his/her eligibility and participation including, but not limited to, his/her records relating to enrollment and attendance, academic standing, age, discipline, residence and physical fitness.

The Student Participation Clearance Form is required for all students to participate in MHSAA athletic and activity programs.

Parent/ Legal Guardian: _____ Phone #: _____

Cell #: _____ Date: _____ (valid 365 days from this 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 |