

**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
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sudden Death	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease / High Pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	_____

**ATHLETE'S ORTHOPAEDIC HISTORY**

Has the athlete had any of the following injuries?

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

Previous Surgeries: \_\_\_\_\_

**ATHLETE'S MEDICAL HISTORY**

Has the athlete had any of these conditions?

<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Organ Loss	<input type="checkbox"/>	<input type="checkbox"/>	Overnight in hospital
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath / coughing during exercise	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Knocked out	<input type="checkbox"/>	<input type="checkbox"/>	Rapid weight loss / gain
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Pulse	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Take supplements / vitamins
<input type="checkbox"/>	<input type="checkbox"/>	Single Testicle	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heat related problems
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual irregularities
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Recent Mononucleosis / Enlarged Spleen
<input type="checkbox"/>	<input type="checkbox"/>	Surgery - What Type?	_____					
<input type="checkbox"/>	<input type="checkbox"/>	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 \_\_\_\_\_, 20\_\_\_\_, 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 _____					
<b>FLEXIBILITY</b>					
	<b>LEFT</b>	<b>RIGHT</b>	<b>FLEXIBILITY</b>	<b>LEFT</b>	<b>RIGHT</b>
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

VISION L \_\_\_\_\_ R \_\_\_\_\_

Comments: \_\_\_\_\_

Comments \_\_\_\_\_

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

Typed or Printed Name of Physician \_\_\_\_\_

Signature of Physician \_\_\_\_\_, M.D.

PHYSICIAN - WHITE SCHOOL - CANARY PARENT/GUARDIAN - PINK

**DO NOT FOLD FORM**

Parent Section