HERNANDO BAND
MEDICAL RELEASE FORM

I, _____ (PARENT/GUARDIAN), HEREBY GIVE PERMISSION FOR ANY AND ALL MEDICAL ATTENTION TO BE ADMINISTERED TO MAY CHILD _____ (CHILD'S NAME) IN THE EVENT OF ACCIDENT, INJURY, SICKNESS, ETC. UNDER THE DIRECTION OF THE PERSON(S) LISTED BELOW, UNTIL SUCH TIME AS I MAY BE CONTACTED. I ALSO ASSUME THE RESPONSIBILITY FOR THE PAYMENT OF ANY SUCH TREATMENT. THIS RELEASE IS EFFECTIVE FOR THE PERIOD OF ONE YEAR FROM THE DATE GIVEN BELOW.

ADDRESS: _____

_____

PHONE NUMBERS: MOM: _____ DAD: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

IN CASE I CANNOT BE REACHED, ANY OF THE FOLLOWING PERSONS IS DESIGNATED TO ACT ON MY BEHALF.

LEN KILLOUGH- DIRECTOR OF BANDS
VICTORIA JONES- ASSISTANT DIRECTOR OF BANDS
JOE QUINNELLY- ASSISTANT DIRECTOR OF BAND
TYLER HARRIS- ASSISTANT DIRECTOR OF BANDS
JEREMY DRIVER- COLORGUARD INSTRUCTOR
ANY CHAPERONE ATTENDING THE TRIP

PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

KNOWN ALLERGIES OR MEDICAL PROBLEMS: _____

_____

MEDICATIONS TAKEN ON A REGULAR BASIS: _____

_____

DOES STUDENT HAVE ASTHMA?_____ IF YES, YOU MUST HAVE AN ASTHMA PLAN ON FILE WITH THE SCHOOL- PLEASE ATTACH A COPY OF THE ASTHMA PLAN TO THIS SHEET.

SIGNATURE (PARENT/GUARDIAN): _____

DATE: _____

2018-2019 STUDENT PARTICIPATION CLEARANCE FORM

I hereby give consent for my child, _____, to participate in the DESOTO COUNTY School District's athletic and activities programs during the 2018-2019 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 i n any supervised school 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 DESOTO COUNTY 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 i n all organized sports and activities and further certify that my child is covered under the health and accident program listed below.

School day insurance:_____Other insurance:_____

Policy # _____Policy #_____

In addition, I assume any expenses for liability not covered by the insurance policy above for injury received by the above named student while participating in sports and school activities. I accept full responsibility for medical and hospital expenses and any other related expenses and do hereby hold harmless the DESOTO COUNTY 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 MHSA A, upon its request, of all records relevant to his/her eligibility and pa11icipation 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)

DO NOT FOLD FORM

MISSISSIPPI ATHLETIC PRE-PARTICIPATION FORM

Please Print

Name _____ Date _____

School HERNANDO HIGH Grade _____ Sport(s) BAND

Sex: M F Date of Birth _____ Age _____ Phone/Cell _____

Address _____ City _____ State _____ Zip _____

Race (circle) African/American White Hispanic Asian Other

Parent / Guardian Name _____ Work Phone _____

FAMILY MEDICAL HISTORY

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

Yes	No	Condition	Please explain any "Yes"
☐	☐	Heart Attack	
☐	☐	Sudden Death	
☐	☐	Stroke	
☐	☐	Heart Disease / High Pressure	
☐	☐	Diabetes	
☐	☐	Sickle Cell Trait / Anemia	
☐	☐	Sudden Infant Death	
☐	☐	Drowning or near drowning	
☐	☐	Pacemaker or implantable defibrillator	
☐	☐	Hypertrophic cardiomyopaththy	
☐	☐	Marfan syndrome	
☐	☐	Arrhythmogenic right ventricular cardiomyopathy	
☐	☐	Long QT syndrome	
☐	☐	Short QT syndrome	
☐	☐	Brugada syndrome	
☐	☐	Catecholaminergic polymorpphic ventricular tachycardia	

ATHLETE'S ORTHOPAEDIC HISTORY

Has the athlete had any of the following injuries?

Yes	No	Condition	Date
☐	☐	Concussion	
☐	☐	Shoulder L / R	
☐	☐	Elbow L / R	
☐	☐	Hip	
☐	☐	Knee L / R	
☐	☐	Foot L / R	
☐	☐	Pinched Nerve	
☐	☐	Transient Quadriplegia / Stenosis	
☐	☐	Neck Injury / Stinger	
☐	☐	Arm / Wrist / Hand L / R	
☐	☐	Back	
☐	☐	Thigh L / R	
☐	☐	Lower Leg L / R	
☐	☐	Ankle L / R	
☐	☐	Chest	

☐ ☐ Have you ever had any numbness, tingling or weakness in your arms or legs after being hit or falling?

☐ ☐ Have you ever been unable to move both arms and both legs after being hit or falling?

Previous Surgeries: _____

ATHLETIC MEDICAL HISTORY

Has the athlete had any of these conditions?

Yes	No	Medical	Yes	No	Medical	Yes	No	Cardiac
☐	☐	Kidney Disease	☐	☐	Hernia	☐	☐	Medications _____
☐	☐	Single Testicle	☐	☐	Rapid weight loss / gain	☐	☐	Heart Murmur
☐	☐	High Blood Pressure	☐	☐	Take supplements / vitamins	☐	☐	High Blood Pressure
☐	☐	Organ Loss	☐	☐	Heat related problems	☐	☐	Heart Infection
☐	☐	Previous Surgeries	☐	☐	Menstrual irregularities	☐	☐	Seizures
☐	☐	Shortness of breath with exercise	☐	☐	Recent Mononucleosis	☐	☐	Irregular Heartbeat
☐	☐	History of Asthma	☐	☐	Enlarged Spleen	☐	☐	Dizzy or Fainting with Exercise
☐	☐	Diabetes (circle): Type I Type II	☐	☐	Sickle Cell Trait / Disease	☐	☐	Heart Disease / Marfan's / Kawasaki's
☐	☐	Liver Disease	☐	☐	Vision loss: significant loss of vision in one eye	☐	☐	Excessive Shortness of Breath w/Exercise
☐	☐	Tuberculosis						
☐	☐	Overnight in hospital	☐	☐	Allergies (Food, Drugs) _____	☐	☐	Chest Pain or Tightness w/Exercise

Please explain any "Yes" _____

WAIVER FORM

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.

This waiver, executed this _____ day of _____, 20_____, by _____, 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 PARENT (or Patient if 18 or older)

DO NOT FOLD FORM

Information below to be filled out by physician only

Height _____ Weight _____ Blood Pressure _____ Pulse _____

General Medical Exam:

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

Comments _____

Flexibility Exam:

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

Comments _____

Orthopaedic Exam:

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

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

_____ _____, M.D.

Typed or Printed Name of Physician SIGNATURE OF PHYSICIAN

DO NOT FOLD FORM

AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization for release of protected health information is provided by MSK Group, P.C. ("MSK"). Please see the Patient Notice for information regarding how your medical information may be used or disclosed.. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Compliance Officer of MSK. The Notice is also posted at MSK offices and on the MSK website.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED .**
- **WE WILL NOT CONDITION YOUR TREATMENT ON THIS AUTHORIZATION.**
- **WE WILL PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPLETED BY STUDENT OR PARENT/LEGAL GUARDIANCE

I, (Print Student's Name)_____, Date of Birth _____
do hereby authorize MSK to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that information released under this authorization may be redisclosed by the recipient of the information and may no longer be protected by state and federal law.

I hereby authorize MSK to release my medical information and related information regarding my physical condition or regarding any injury, illness or condition that I sustain due to my involvement in activities at my school, _____to a coach, team member, administrative staff of my school, family member or legal guardian for purposes of enhancing my safety in connection with my participation or presence at school-related activities and to establish open lines of communication regarding my medical condition and status. I understand this information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information.

I understand that I may withdraw my authorization in writing to the Compliance Officer of MSK at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire **upon the later date of my graduation or the completion of my participation in school-related events.** I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Signatures: All students must sign this consent. If the student is under 18 years of age at the time of signature, a parent or legal guardian must sign this authorization as well. By signing this authorization, the student understands that it will continue to be in effect upon the student turning 18 years of age.

I, _____, parent and/or legal guardian of _____, student, acknowledge that I am authorized to provide my consent and by signing this form provide my authorization and consent for the release of protected health information of the above named student for the limited purposes described above.

_____ DATE: _____

Please Print Signatory's Name:_____

Address: _____

Relationship to Student (if Student is under 18 years of age): _____

Student's Signature: _____

Please Print Student's Name: _____

CONSENT FOR MEDICAL TREATMENT
MSK Group, P.C. on Behalf of (the "School")

This authorization/consent will allow MSK Group, P.C. ("MSK") health care providers to provide students with medical services and treatment on behalf of the School as set forth below.

Consent for Medical Treatment

I _____(please print student's name) hereby authorize MSK, its Athletic Trainers, employees and staff (or their designee) to render any and all medical evaluation and/or treatment, including without limitation, the use of necessary x-rays, injections, casting, bracing, or other diagnostic tests, during my participation in activities with the School or due to any injury that I may sustain while on School premises or incurred during my participation in School-related events. I further authorize MSK, its Athletic Trainers, employees and staff (or their designee) to render any necessary follow-up medical evaluation and/or treatment, including without limitation, the use of x-rays, injections, casting, bracing or other diagnostic tests, performed at MSK or any of its affiliated clinics.

SIGNATURE OF STUDENT:

Expiration: This consent will expire upon the later of the student's graduation or the completion of the student's participation in School-related events.

Signatures: All students must sign this consent. If the student is under 18 years of age at the time of signature, a parent or legal guardian must sign this authorization/consent as well. By signing this consent, the student understands that it will continue to be in effect upon the student turning 18 years of age.

I, _____, parent and/or legal guardian of _____, student, acknowledge that I am authorized to provide my consent and by signing this form provide my authorization and consent for the drug testing and medical treatment of the above named student for the limited purposes described above.

_____ DATE: _____

Please Print Signatory's Name: _____

Address: _____

Relationship to Student (if Student is under 18 years of age): _____

Student's Signature: _____

Please Print Student's Name: _____

Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A youth athlete's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- fainting or seizures during exercise;
- unexplained shortness of breath;
- dizziness;
- extreme fatigue;
- chest pains; or
- racing heart.

These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

! All youth athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.

Adapted from PA Department of Health: Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form. 7/2013

! The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptoms:
(i) Unexplained shortness of breath;
(ii) Chest pains;
(iii) Dizziness
(iv) Racing heart rate; or (v) Extreme fatigue; and

! Establish as policy that a youth athlete who has been removed from play shall not return to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest

! Before returning to practice or play in an athletic activity, the athlete must be evaluated by a Mississippi licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.
I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete Print Student Name

Signature of Parent/Guardian Print Parent/Guardian Name

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)

CONCUSSION FORM

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 fully 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