DO NOT FOLD FORM

MISSISSIPPI ATHLETIC PRE-PARTICIPATION FORM

Please Print

Name _____ Date _____

School _____ Grade _____ Sport(s) _____

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

ATHLETE'S ORTHOPAEDIC HISTORY

Has the athlete had any of the following injuries?

Yes	No	Condition	Date	Yes	No	Condition	Date
☐	☐	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	
☐	☐	Foot L / R		☐	☐	Ankle L / R	
☐	☐	Pinched Nerve		☐	☐	Chest	
☐	☐	Transient Quadriplegia / Stenosis					

☐ ☐ 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 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 PARENT (or Patient if 18 or older)

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

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

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: _____

2019-2020 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 2019-2020 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 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)**