DO NOT FOLD FORM

MISSISSIPPI ATHLETIC PARTICIPATION FORM

ATHLETIC HEALTH HISTORY

Please Print

Parent to Complete

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

Doctor to Complete

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**

______________________ Typed or Printed Name of Physician

______________________, M.D. **Signature of Physician**

PHYSICIAN - WHITE SCHOOL - CANARY PARENT/GUARDIAN - PINK

DO NOT FOLD FORM

MSMOC 62 Rev. 3/03

Emergency Information Card

Athlete's Name:____Age:__________

Address: ____S.S. #__________________

Phone (Home): (______)__________________(Cell):(______)____________________

List two persons to contact in case of emergency:

Parent or Guardian's Name:____

Address: __________________________________City: ________________ State: _____

Home Phone: (______)___________________ Work Phone: (______)________________

Second Person's Name: ____

Address:_________________________________ City: _________________ State: _____

Home Phone: (______)__________________ Work Phone: (______)________________

Relationship to Athlete: ____

Insurance Company: ___________________________ Policy No:___________________

Physician's Name: ________________________ Phone: (______)___________________

IMPORTANT

Are you allergic to any drugs?_________ If so, what ? _____________________________

Do you have any other allergies? (i.e., bee sting, dust) ______________________________

Do you suffer from _____Asthma _____Diabetes or _____ Epilepsy? (Check any that apply)

Are you on any medication: ________ If so, what? _______________________________

Do you wear contacts? __________________________

Other: ____

Signature: ____________________________________ Date: ____________________

DIOCESE OF JACKSON
ST. JOSEPH HIGH SCHOOL
Athletic Participation Agreement

I understand that the advancement of the Gospel mission of Catholic education is the key purpose of all programs, including athletics, at **St. Joseph School**. Dignity and respect for each individual are some of the basic Gospel values taught throughout the curriculum. Athletics in a Catholic school is an important way of teaching and training young men and women to cope with life in competitive circumstances and also reflect the Gospel values of Jesus Christ and the mission of the school.

I hereby request **St. Joseph School** to grant permission for my son/daughter to participate in **St. Joseph School** athletics. I understand that I am entering into a voluntary contract between myself, the parent/guardian of a **St. Joseph School** student, and **St. Joseph School** for participation in school sponsored athletic activities.

I agree to cooperate with and support the rules and regulations of the Diocese of Jackson, the Mississippi High School Activities Association and of **St. Joseph School** and to be governed by these rules and regulations as announced to me by the principal of **St. Joseph School**, as published in the Student-Parent School Handbook, and as announced or published in other places by the school administration. I understand that I must be familiar with and accountable for these rules and regulations and the policies and procedures which govern participation in athletics representing **St. Joseph School**.

As a player, my son/daughter understands that he/she must fulfill all religious and academic responsibilities to **St. Joseph School** and conduct himself/herself as a committed Christian in school, outside of school, and in particular at any activity involving athletic competition representing **St. Joseph School**. My son/daughter agrees to be bound by the rules and regulations regarding athletics and to submit himself/herself voluntarily to the application of the rules.

As a parent/guardian of a **St. Joseph School** athletic participant, I understand my responsibility and obligation to see that my son/daughter fulfills his/her religious and academic responsibilities including school work and homework assignments and complies with the rules and regulations for participation in **St. Joseph School** athletics.

I further agree that as an adult I will conduct myself in a responsible and mature Christian manner at all times at all practices and games, that I will show respect for authority, and will engage in no activity or conduct which in any way is disrespectful, combative or confrontational, or questions the jurisdiction of the school principal, coach, officials, or anyone connected with the conduct of **St. Joseph School** athletics.

As player and parent/guardian, we acknowledge that a violation of any of these rules and regulation may result in forfeiture of ability to participate in athletics or attend athletic events representing **St. Joseph School**.

Our signatures mean that we understand and accept these conditions of the participation of our son/daughter and our family, which are binding through our son/daughter's school year at **St. Joseph School**.

STUDENT NAME: ______________________________

STUDENT SIGNATURE: ______________________________ DATE: ______________

PARENT/GUARDIAN NAME: ______________________________

PARENT/GUARDIAN SIGNATURE: ______________________ DATE: ______________

ST. JOSEPH CATHOLIC SCHOOL
1501 VFW ROAD
GREENVILLE, MS 38701

TO: ST. JOSEPH SCHOOL

MY SON/DAUGHTER, ______________________________, IS COVERED UNDER MY FAMILY HEALTH INSURANCE PLAN. THIS PLAN WILL COVER ANY EXPENSES THAT MIGHT OCCUR SHOULD MY SON/DAUGHTER BE INJURED WHILE PARTICIPATING IN ATHLETICS HERE AT ST. JOSEPH. I WILL NOT HOLD ST. JOSEPH SCHOOL OR ANY SCHOOL PERSONNEL LIABLE FOR ANY COST OR INJURY THAT MIGHT OCCUR WHILE PARTICIPATING IN PRACTICE OR GAMES.

______________________________ ______________
PARENT'S SIGNATURE DATE

ATHLETIC AUTHORIZATION FORM

I / WE GIVE OUR PERMISSION FOR ____________________________________ TO PARTICIPATE IN ORGANIZED HIGH SCHOOL ATHLETICS, REALIZING THAT SUCH ACTIVITY INVOLVES THE POTENTIAL FOR INJURY WHICH IS INHERENT IN ALL SPORTS. I / WE ACKNOWLEDGE THAT EVEN WITH THE BEST COACHING, USE OF THE MOST ADVANCED PROTECTIVE EQUIPMENT AND STRICT OBSERVATION OF RULES, INJURIES ARE STILL A POSSIBILTY. ON RARE OCCASIONS THESE INJURIES CAN BE SO SEVERE AS TO RESULT IN TOTAL DISABILITY, PARALYSIS OR EVEN DEATH.

I / WE ACKNOWLEDGE THAT I / WE HAVE READ AND UNDERSTOOD THIS WARNING.

______________________________ ______________
PARENT/GUARDIAN DATE

______________________________ ______________
PARENT/GUARDIAN DATE

______________________________ ______________
PLAYER 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