



MISSISSIPPI ATHLETIC PARTICIPATION FORM
ATHLETIC HEALTH HISTORY
-DO NOT FOLD FORM-

Community Service Complex
1001 S. Harper Road
Corinth, MS 38834
(662) 287-1400

Name: Grade next year:
Sex: Male Female Date of Birth: Age:
Address:
Family Physician:
Parent/Guardian Name:
SSN: Emergency Phone:
Work Phone: Mobile Phone:

School:

Sports Next Year

- Band/Color Guard
Baseball
Basketball
Bowling
Cheerleading
Cross Country
Dance
Fast-Pitch
Football
Golf
Powerlifting
Slow-Pitch
Soccer
Tennis
Track and Field
Volleyball

FAMILY MEDICAL HISTORY

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

Table with columns: Yes, No, Condition, Whom. Lists conditions like Heart Attack, Sudden Death, Stroke, etc.

ATHLETE'S ORTHOPAEDIC HISTORY

Has the athlete had any of the following injuries?

Table with columns: Yes, No, Condition (indicate L or R), YEAR. Lists injuries like Head Injury, Shoulder, Hip, etc.

Explain "Yes" answers:

ATHLETE'S MEDICAL HISTORY

Has the athlete had any of these conditions?

Table with columns: Yes, No, Condition. Lists conditions like Heart Murmur, Seizures, Kidney Disease, etc.

Explain "Yes" answers:

Date of Last Tetanus Immunization (YEAR):

I hereby state that my answers to these questions are correct to the best of my knowledge.

Signature of Athlete: Date:

INFORMATION BELOW TO BE FILLED OUT BY MEDICAL PERSONNEL ONLY

Height ' " Weight Lbs. Blood Pressure / Re-check by MD /

ORTHOPAEDIC EXAM

Table for Orthopaedic Exam with columns: Norm, Abnl, Scoliosis. Lists Spine/Neck, Upper Extremity, Lower Extremity.

GENERAL MEDICAL EXAM

Table for General Medical Exam with columns: Norm, Abnl. Lists Ears, Nose, Throat, Eyes, Lungs, Heart, etc.

FLEXIBILITY

Hamstrings ___Poor ___Fair ___Average ___Good ___Excellent

VISION L 20/ R 20/ Glasses on Contacts in

General Health Comments

PARTICIPATION LEVEL

- [] From this limited screening I see no reason why this student cannot participate in athletics.
[] Student needs further evaluation by regular family physician.

Physician/Clinician Physician/Clinician



Magnolia Regional Health Center Pre-participation Exam Student Waiver

Federal law protects physicians who provide athletic physicals on a voluntary basis. The law requires physicians to obtain a signed waiver from the student’s parent/guardian unless that student is 18 or older. Students who have not completed the following waiver may not participate in the physicals provided by Magnolia Regional Health Center. A parent/guardian must sign and return the form to Magnolia Rehab on the night of your physical.

This waiver is executed in compliance with Mississippi law, which states 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 acts of willful or gross negligence.

Magnolia Regional Health Center Athletic Release-of-Liability

In consideration of participation in pre-season athletic evaluation, I fully and finally release Magnolia Regional Health Center and all of their officers, directors, trustees, employees, or other agents for any claim, rights, or causes of action that may occur from my participation.

Magnolia Regional Health Center (Sports Medicine) Permission for Treatment

In the event that I cannot be reached by telephone, I grant permission to Magnolia Regional Health Center’s Department of Rehabilitation Services, section of Sports Medicine, to provide medical treatment for my son/daughter listed on the line below. Although this is a free service, consent is needed for both evaluation and treatment of your son/daughter. Charges for services rendered will not be incurred unless an athlete is seen by a physician and referred to our facility to begin physical therapy.

Magnolia Regional Health Center Confidentiality Waiver

By signing below, I grant permission to all Certified Athletic Trainer(s) and other medical personnel to discuss with physicians, nurse practitioners, and coaches any pertinent information regarding my child’s injury, diagnosis, medical condition, medications, treatment, rehabilitation program, follow-up care, and any other necessary medical information pertaining to the well-being of my child.

Signing below states you have read and understand all waivers and releases aforementioned on this page.

This must be signed in order for your child to receive a pre-participation physical OR be treated by an athletic trainer at Magnolia Outpatient Rehabilitation and/or on the field of play or practice.

<hr/> SIGNATURE OF PARENT OR GUARDIAN	<hr/> PRINTED NAME OF ATHLETE	<hr/> DATE
<hr/> ADDRESS	<hr/> SIGNATURE OF ATHLETE	<hr/> PHONE #
<hr/> PHYSICIAN/CLINICIAN SIGNATURE	<hr/> PHYSICIAN/CLINICIAN SIGNATURE	