

ATHLETIC PARTICIPATION CLEARANCE FORM

I hereby give consent for my child, _____, to participate in the Picayune School District's athletic program during the 2017-2018 school year.

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 in any supervised school related sports 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 Picayune 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 required for participation in all organized athletic activities and further certify that my child is covered under the health and accident program listed below.

School day insurance _____
Policy # _____

School day insurance is available online at the Picayune School District website:
www.pcu.k12.ms.us.

Other insurance _____
Policy # _____
Name of Agent _____

The Picayune School District is prohibited by law from paying any expense incurred for any accident involving a student on school property or participating in school activities and does not provide health or accident insurance for participants in athletic programs.

In addition, I assume any expenses for liability not covered by the above required insurance policy for injury received by the above named student while participating in sports authorized above. I accept full responsibility for medical and hospital expenses and any other related expenses and do hereby hold harmless the Picayune 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 athletics involves the potential for injury which is inherent in all sports, sometimes severe enough to result in total disability, paralysis, or death.

Parent/Legal Guardian _____

Date _____

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 _____, 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

Height _____	Weight _____	Blood Pressure _____	Pulse _____
Orthopaedic Exam		General Medical Exam	
	Norm Abnl	Norm Abnl	Norm Abnl
I. Spine / Neck	_____	ENT	_____
Cervical	_____	Heart	_____
Thoracic	_____	Skin	_____
Lumbar	_____	General Health Comments	_____
II. Upper Extremity	_____		
Shoulder	_____	FLEXIBILITY	LEFT RIGHT
Elbow	_____	Neck	_____
Wrist	_____	Hips	_____
Hand / Fingers	_____	Hams	_____
III. Lower Extremity	_____	Back Ext / Flex	_____
Hip	_____	Comments	_____
Knee	_____		
Ankle	_____		
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
 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 _____

Signature of Physician _____, M.D.

PHYSICIAN - WHITE SCHOOL - CANARY PARENT/GUARDIAN - PINK

DO NOT FOLD FORM