

Name: _____
 Last First Middle Birthdate Age

Sport/Activity: ___Football ___Volleyball ___Soccer ___Basketball ___Golf ___Tennis
 [Check all ___Baseball ___Wrestling ___Softball ___Swimming ___Cross Country
 that apply] ___Track ___Kilties ___Band ___Dance/Poms ___Cheerleading

Address: _____
 Street City/State Zip Phone

 Mother / Guardian Name Home Phone Work Phone

 Father / Guardian Name Home Phone Work Phone

 Emergency Contact Person: Name Home Phone Work Phone

Family Doctor: _____ Hospital of Choice: _____

Medical History

Please answer the following questions by circling yes or no. If you answer yes, please explain at the bottom of the form and on back if necessary.

- | | | |
|---|-----|----|
| 1. Have you ever had a serious medical problem requiring surgery, hospitalization or prolonged treatment by a doctor? | Yes | No |
| 2. Do you take any medication of any type? | Yes | No |
| 3. Have you ever had a severe allergic reaction to anything? | Yes | No |
| 4. Have you ever had allergic problems such as hay fever, asthma or eczema? | Yes | No |
| 5. Do you have difficult breathing or wheezing during or shortly after exercising? | Yes | No |
| 6. Have you ever had a heart murmur, racing heart or irregular heart beat? | Yes | No |
| 7. Have you ever been dizzy or passed out during exercise?* | Yes | No |
| 8. Has any family member ever had a heart attack or died suddenly before age 50? | Yes | No |
| 9. Do you have chest pain or tire more easily than others your age when exercising? | Yes | No |
| 10. Have you ever suffered heat related problems such as heat cramps, severe headache, dizziness or passing out? | Yes | No |
| 11. Have you ever had a significant injury such as a sprain, fracture or dislocation to a bone or joint? | Yes | No |
| 12. Have you ever had a concussion or been knocked unconscious? | Yes | No |
| 13. Have you ever had a seizure? | Yes | No |
| 14. Have you ever had burning pain, numbness or tingling in your arms or legs associated with any athletic or physical activity? | Yes | No |
| 15. Is there any other medical or family history which might be important? | Yes | No |
| 16. Have you ever been taken out of or kept from participating in a sports activity or practice for an injury or physical reason? | Yes | No |
| 17. Have you ever required taping, padding or bracing before events or practice? | Yes | No |
| 18. Do you have damage or absence of one of any paired organs (i.e., kidney, testicle, eye, etc.)? | Yes | No |
| 19. Do you have any skin problems (rash, itching)? | Yes | No |
| 20. In the last year, how much weight have you gained or lost? _____ | | |
| 21. What is the date of your last tetanus booster? _____ | | |
| 22. What is the date of your last MMR? _____ | | |
| For Females Only: | | |
| 23. What is the date of your last menstrual period? _____ | | |
| 24. In the last year have you gone for three months or more without a menstrual cycle? | Yes | No |

Student Agreement Regarding Conditions for Participation:

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them. I also understand that if I do not meet the citizenship standards set by the school or if I am ejected from an interscholastic contest because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

X Student's Signature _____ Date _____

Parent Permission and Authorization for Treatment:

We hereby give our consent for the above student to represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it be enroute to or from another school or during practice or an interscholastic contest, and we hereby agree to hold the school district of which this school is a part, its employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school.

If we cannot be reached and in the event of an emergency, we also give our consent for the school to obtain through a physician or hospital or certified athletic trainer of its choice, such medical care as is reasonably necessary for the welfare of the student, if he/she is injured in the course of school athletic activities. We understand that the school may not provide transportation to all events, and **permit / do not permit** (CIRCLE ONE) my child to drive his/her vehicle in such a case.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment and we certify that it is correct and complete.

We confirm that this application for the above student to represent his/her school in interscholastic athletics is made with the understanding that we have studied and understand the eligibility standards that our son/daughter must meet to represent his/her school and that he/she has not violated any of them. We also understand that if our son/daughter does not meet the citizenship standards set by the school or if he/she is ejected from an interscholastic contest because of an unsportsmanlike act, it could result in him/her not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he/she has basic health/accident insurance coverage, which includes athletics. Our son/daughter is covered by basic health/accident insurance for the current school year with

X _____ (Policy Number) _____

(Name of Insurance Company)

X _____
 Parents or Guardian's Signature[s](All parents or guardians must sign)

Date: _____

Athletic Physical Exam

height _____ blood pressure _____ * >140/85? _____
weight _____ pulse _____
vision R corrected _____ uncorrected _____
L corrected _____ uncorrected _____
glasses _____ contact lenses R ___ L ___ both ___
general observations: _____
Tanner maturity staging: _____
HEENT: _____
Neck: ROM _____ palpation _____ tenderness _____
Chest: auscultation _____ wheezing? _____ Rales? _____
CV: heart murmur _____
* murmur increase with valsalva? _____
* murmur grade III or IV? _____
* murmur diastolic? _____
rhythm _____ click _____ rub _____
pulses: carotid _____ radial _____ pedal (DP _____ PT _____)
edema? _____ cyanosis? _____
Abdomen* enlarged liver? _____
*enlarged spleen? _____
hernia? _____ scars? _____
GU: male _____ testicles R ___ L _____
female _____
inguinal hernia? _____
Skin: gen. _____
rashes _____ impetigo _____ herpes s. _____
**MS shoulder _____
elbow _____
wrist/hand _____
back _____
hip _____
knee _____
ankle _____
feet _____
other _____
identified problems: 1 _____
2 _____
3 _____
recommendations coach/trainer: _____

* Marfan? >2 tall _____ striae _____ hyperextensibility _____
upper to lower body ratio <0.9 _____ lens dislocation _____
* requires additional evaluation
** detailed exam if history of injury or problem

[Student's Full Name Printed Here]

The above named individual has been cleared for participation in the following sports:

- _____ Contact collision (football, soccer, wrestling, etc.)
- _____ Limited contact impact (baseball, basketball, volleyball)
- _____ Noncontact strenuous (track, field, running, tennis, etc.)
- _____ Noncontact moderately strenuous (badminton, table tennis)
- _____ Noncontact nonstrenuous (golf, archery, riflery)

Additional evaluation suggested:

- _____ none
- _____ coach/trainer notification and clearance
- _____ physician
- _____ family physician _____
- _____ sports physician _____
- _____ orthopedic surgeon _____
- _____ other _____

X Provider's/Physician's Signature _____

X Physician's Name _____ **X** Date _____

(Physician's name must also appear if examination is given by an Advanced Nurse Practitioner or a Certified Physician's Assistant in written collaborative practice with a physician)

Information Regarding Medical History From Page 1

Known Allergies _____

Current Medications _____

Known Medical Condition[s] _____

Dislocations/Fractures/Surgeries _____

If Currently Under A Physician's Care, Please Explain _____

