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)

2016-2017 STUDENT PARTICIPATION CLEARANCE FORM

I hereby give consent for my child, ____________________________, to participate in the ______________________________School District's athletic and activities programs during the _____________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 in 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 ____________________________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 in 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 ________________________________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 MHSAA, 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 from this date)

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"
☐	☐	Heart Attack	________
☐	☐	Sudden Death	________
☐	☐	Stroke	________
☐	☐	Heart Disease / High Pressure	________
☐	☐	Diabetes	________
☐	☐	Sickle Cell Trait / Anemia	________
☐	☐	Sudden Infant Death	________
☐	☐	Drowning or near drowning	________
☐	☐	Pacemaker or implantable defibrillator	________

Yes	No	Condition	Please explain any "Yes"
☐	☐	Hypertrophic cardiomyopaththy	________
☐	☐	Marfan syndrome	________
☐	☐	Arrhythmogenic right ventricular cardiomyopathy	________
☐	☐	Long QT syndrome	________
☐	☐	Short QT syndrome	________
☐	☐	Brugada syndrome	________
☐	☐	Catecholaminergic polymorpphic ventricular tachycardia	________

ATHLETE'S ORTHOPAEDIC HISTORY

Has the athlete had any of the following injuries?

Yes	No	Condition	Date
☐	☐	Concussion	________
☐	☐	Shoulder L / R	________
☐	☐	Elbow L / R	________
☐	☐	Hip	________
☐	☐	Knee L / R	________
☐	☐	Foot L / R	________
☐	☐	Pinched Nerve	________
☐	☐	Transient Quadriplegia / Stenosis	________

Yes	No	Condition	Date
☐	☐	Neck Injury / Stinger	________
☐	☐	Arm / Wrist / Hand L / R	________
☐	☐	Back	________
☐	☐	Thigh L / R	________
☐	☐	Lower Leg L / R	________
☐	☐	Ankle L / R	________
☐	☐	Chest	________

☐ ☐ 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
☐	☐	Kidney Disease
☐	☐	Single Testicle
☐	☐	High Blood Pressure
☐	☐	Organ Loss
☐	☐	Previous Surgeries
☐	☐	Shortness of breath with exercise
☐	☐	History of Asthma
☐	☐	Diabetes (circle): Type I Type II
☐	☐	Liver Disease
☐	☐	Tuberculosis
☐	☐	Overnight in hospital

Yes	No	Medical
☐	☐	Hernia
☐	☐	Rapid weight loss / gain
☐	☐	Take supplements / vitamins
☐	☐	Heat related problems
☐	☐	Menstrual irregularities
☐	☐	Recent Mononucleosis
☐	☐	Enlarged Spleen
☐	☐	Sickle Cell Trait / Disease
☐	☐	Vision loss: significant loss of vision in one eye
☐	☐	Allergies (Food, Drugs) ________

Yes	No	Cardiac
☐	☐	Medications ________
☐	☐	Heart Murmur
☐	☐	High Blood Pressure
☐	☐	Heart Infection
☐	☐	Seizures
☐	☐	Irregular Heartbeat
☐	☐	Dizzy or Fainting with Exercise
☐	☐	Heart Disease / Marfan's / Kawasaki's
☐	☐	Excessive Shortness of Breath w/Exercise
☐	☐	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)**

DO NOT FOLD FORM

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

____________________ Typed or Printed Name of Physician

____________________, **M.D.**
SIGNATURE OF PHYSICIAN

DO NOT FOLD FORM