DO NOT FOLD FORM

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
ATHLETIC PARTICIPATION FORM

UMMC Sports Medicine

Please Print

Name _____ Date _____

School _____ Grade _____ Sport(s) _____

Sex: M F Date of Birth _____ S.S.N. _____ Age _____

Parent/Guardian Name _____ Work Phone _____

Address _____ Home Phone _____

Family Physician _____ Work Phone _____

FAMILY MEDICAL HISTORY

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

Yes	No	Condition	Please explain any "Yes"	Yes	No	Condition	Please explain any "Yes"
☐	☐	Heart Attack	_____	☐	☐	Hypertrophic cardiomyopathy	_____
☐	☐	Sudden Death	_____	☐	☐	Marfan syndrome	_____
☐	☐	Heart Disease	_____	☐	☐	Arrhythmogenic right ventricular cardiomyopathy	_____
☐	☐	High Pressure	_____				
☐	☐	Diabetes	_____	☐	☐	Long QT syndrome	_____
☐	☐	Sickle Cell Trait/Anemia	_____	☐	☐	Short QT syndrome	_____
☐	☐	Sudden Infant Death	_____	☐	☐	Brugada syndrome	_____
☐	☐	Drowning or near drowning	_____	☐	☐	Catecholaminergic polymorpphic ventricular tachycardia	_____
☐	☐	Pacemaker or implantable defibrillator	_____				

ATHLETE'S ORTHOPAEDIC HISTORY

Has the athlete had any of the following injuries?

Yes	No	Condition	Date	Yes	No	Condition	Date
☐	☐	Condition	_____	☐	☐	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 L / R	_____	☐	☐	Ankle L / R	_____
☐	☐	Foot L / R	_____	☐	☐	Severe Muscle Strain	_____
☐	☐	Pinched Nerve	_____	☐	☐	Chest	_____

Surgeries: _____

ATHLETE'S MEDICAL HISTORY

Has the athlete had any of these conditions?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Shortness of breath/ coughing during exercise	☐	☐	Head Injury/Concussion	☐	☐	Overnight in hospital
☐	☐	Chest pain/Tightness	☐	☐	Loss of consciousness/"Knocked out"	☐	☐	Hernia
☐	☐	Asthma	☐	☐	Seizures	☐	☐	Rapid weight loss/gain
☐	☐	Dizzy/Fainting	☐	☐	Kidney Disease	☐	☐	Take supplements/vitamins
☐	☐	Heart murmur	☐	☐	Single Testicle	☐	☐	Menstrual irregularities
☐	☐	Irregular pulse	☐	☐	Organ loss	☐	☐	Recent Mononucleosis/Enlarged Spleen
☐	☐	Heart Disease	☐	☐	Diabetes	☐	☐	Sickle Cell Trait/Disease
☐	☐	High Blood Pressure	☐	☐	Liver Disease			
☐	☐	Heart related problems	☐	☐	Tuberculosis			

☐ ☐ Have you had any serious medical illness/injury since your last sports physical? _____

☐ ☐ Are you currently taking any prescription or non prescription (over the counter) medications? _____

☐ ☐ Allergies (Food, Drugs) _____

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 _____, 201_____, by _____, 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/Guardian (Not required if patient is over 18 yrs old.)

INFORMATION BELOW TO BE FILLED OUT BY PHYSICIAN ONLY

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	_____	_____	Shoulders	_____	_____
Hips	_____	_____	Quadriceps	_____	_____
Hamstrings	_____	_____	Achilles	_____	_____
Back Ext / Flex	_____	_____			

Comments _____

_____

_____

Other Comments _____

OPTIONAL EXAMS

DENTAL

Comments _____

_____

Comments _____

VISION L _____ R _____

Comments: _____

_____ _____

Typed or Printed Name of Physician — **Signature of Physician**

[ ] From this limited screening I see no reason why this student cannot participate in athletics

[ ] Student needs further evaluation as described