

DO NOT FOLD FORM
UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
ATHLETIC PARTICIPATION FORM



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"
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hypertrophic cardiomyopathy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sudden Death	_____	<input type="checkbox"/>	<input type="checkbox"/>	Marfan syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmogenic right ventricular cardiomyopathy	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Pressure	_____	<input type="checkbox"/>	<input type="checkbox"/>	Long QT syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	Short QT syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait/Anemia	_____	<input type="checkbox"/>	<input type="checkbox"/>	Brugada syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sudden Infant Death	_____	<input type="checkbox"/>	<input type="checkbox"/>	Catecholaminergic polymorphic ventricular tachycardia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drowning or near drowning	_____				
<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury / Stinger	_____
<input type="checkbox"/>	<input type="checkbox"/>	Elbow L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Arm / Wrist / Hand L / R	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hip	_____	<input type="checkbox"/>	<input type="checkbox"/>	Back	_____
<input type="checkbox"/>	<input type="checkbox"/>	Knee L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Thigh L / R	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Shin Splints L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Lower Leg L / R	_____
<input type="checkbox"/>	<input type="checkbox"/>	Foot L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ankle L / R	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pinched Nerve	_____	<input type="checkbox"/>	<input type="checkbox"/>	Severe Muscle Strain	_____
				<input type="checkbox"/>	<input type="checkbox"/>	Chest	_____

Surgeries: _____

ATHLETE'S MEDICAL HISTORY

Has the athlete had any of these conditions?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath/ coughing during exercise	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Overnight in hospital
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/Tightness	<input type="checkbox"/>	<input type="checkbox"/>	Loss of consciousness/"Knocked out"	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Rapid weight loss/gain
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Take supplements/vitamins
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Single Testicle	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual irregularities
<input type="checkbox"/>	<input type="checkbox"/>	Irregular pulse	<input type="checkbox"/>	<input type="checkbox"/>	Organ loss	<input type="checkbox"/>	<input type="checkbox"/>	Recent Mononucleosis/Enlarged Spleen
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait/Disease
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease			
<input type="checkbox"/>	<input type="checkbox"/>	Heart related problems	<input type="checkbox"/>	<input type="checkbox"/>	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 5th day of May, 2018, 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.

RESEARCH STUDY

Members of an investigative team at the University of Mississippi Medical Center are conducting a research study about sport-related concussion.

Your child is being invited to participate in this study because he/she is an athlete in high school sports. If you agree to permit your child to participate, he/she will be asked to complete an electronic survey, which will take about 10 minutes, while getting his/her sports-physical. Your child's participation in this study is voluntary. If you choose not to permit your child to participate, there will be no penalty and it will not affect his/her treatment/care. The survey is anonymous. The results of the study may be published but your child's name will not be known.

If you have any questions concerning the research study, please call Dr. Jennifer Reneker at (601) 984-6326 or JReneker@UMC.edu.

Checking the box below and signing this form will be considered your permission to allow your child to participate. Thank you.

I give permission for my child to complete the survey on concussion

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

GENERAL MEDICAL EXAM

		Norm	Abnl			Norm	Abnl			Norm	Abnl
I.	Spine / Neck	_____	_____	ENT	_____	_____	Lungs	_____	_____		
	Cervical	_____	_____	Heart	_____	_____	Abdomen	_____	_____		
	Thoracic	_____	_____	Skin	_____	_____	Hernia (if Needed)	_____	_____		
	Lumbar	_____	_____	General Health Comments _____							
II.	Upper Extremity	_____	_____								
	Shoulder	_____	_____								
	Elbow	_____	_____	FLEXIBILITY	Left	Right	FLEXIBILITY	Left	Right		
	Wrist	_____	_____	Neck	_____	_____	Shoulders	_____	_____		
	Hand/Fingers	_____	_____	Hips	_____	_____	Quadriceps	_____	_____		
III.	Lower Extremity	_____	_____	Hamstrings	_____	_____	Achilles	_____	_____		
	Hip	_____	_____	Back Ext / Flex	_____	_____					
	Knee	_____	_____	Comments _____							
	Ankle	_____	_____								
	Feet	_____	_____								

Other Comments _____

OPTIONAL EXAMS

DENTAL

Comments _____

VISION L _____ R _____

Comments: _____

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