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.

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 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 _____
(Name of Insurance Company)

_____ _____
(Policy Number) Date

Parents or Guardian's signature _____
(All parents or guardians must sign)

_____ Date _____


***To be completed by athlete or parent:***

Date: _____

Name: _____
Last First Middle

Address: _____
Street

_____ Phone: (_____) _____
City/State Zip

Birthdate: _____ Age: _____ Sex: _____

Emergency Contact Person: _____

Phone: (_____) _____

Family Doctor: _____

City/State: _____ Phone: (_____) _____

# Preparticipation Sports Examination

## *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? _____
23. Do you or any members of your family have a history of sickle cell trait? Yes No Uncertain

**For Females Only:**

24. What is the date of your last menstrual period? _____
25. In the last year have you gone for three months or more without a menstrual cycle? Yes No

## *Physical*

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

**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 _____

Provider's/Physician's signature _____

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

(continued on reverse side)