Mississippi Sports Medicine And Orthopaedic Center

DO NOT FOLD FORM

MISSISSIPPI ATHLETIC PRE-PARTICIPATION FORM

PLEASE PRINT / PLEASE FILL OUT COMPLETELY

ELITE PHYSICAL THERAPY

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	
☐	☐	Hypertrophic cardiomyopathy	
☐	☐	Marfan syndrome	
☐	☐	Arrhythmogenic right ventricular cardiomyopathy	
☐	☐	Long QT syndrome	
☐	☐	Short QT syndrome	
☐	☐	Brugada syndrome	
☐	☐	Catecholaminergic polymorphic 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	
☐	☐	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: _____

ATHLETE'S 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
☐	☐	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
☐	☐	Previously diagnosed or tested positive for COVID-19 Date: _____
☐	☐	Heart Murmur
☐	☐	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 and/or Parent if under 18

SIGNATURE OF PATIENT AND/OR PARENT IF UNDER 18

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Name _____ School _____

Information below to be filled out by physician only

Height _____ Weight _____ Blood Pressure (1) _____ Pulse _____

Blood Pressure (2) _____ Pulse _____
2nd attempt if needed

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

_____ _____, **M.D.**

Typed or Printed Name of Physician **SIGNATURE OF PHYSICIAN**

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