Mississippi Sports Medicine And Orthopaedic Center

DO NOT FOLD FORM

MISSISSIPPI ATHLETIC PRE-PARTICIPATION FORM

Please Print

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**
☐	☐	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

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

[ ] Student needs clearance from primary care physician due to previous positive COVID-19 diagnosis

_____ _____, **M.D.**

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

DO NOT FOLD FORM