



LAFAYETTE COUNTY ATHLETICS PRE-PARTICIPATION HISTORY AND PHYSICAL SCREENING FORM



CONFIDENTIAL INFORMATION

This Pre-Participation Medical History and Physical Screening does not take the place of a comprehensive physical examination which should be performed by your physician.

SCHOOL: _____ **SCHOOL YEAR:** 20____

Full Name: _____ **Gender:** M / F **Date of Birth:** ____/____/____ **Age:** ____

Sport(s): _____ **Name of Family Physician:** _____

List any FOOD or MEDICATION Allergies: _____

| MEDICAL HISTORY (Mark YES , NO , or DON'T KNOW for each question.) | YES | NO | DON'T KNOW |
|--|--------------------------|--------------------------|--------------------------|
| 1. Have you ever become dizzy, passed out or fainted during or after an activity? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been told you have a heart murmur or other heart-related problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does anyone in your immediate family have heart-related or heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has anyone in your family died suddenly (due to an illness or medical condition) before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had a concussion, head injury, neck injury, or been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever suffered a seizure or been diagnosed as having Epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any illnesses or conditions that require you to see a physician on a regular basis? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been treated for medical conditions such as: Meningitis, Hepatitis, HIV/AIDS, Mononucleosis, Diabetes, Hemophilia, Cancer, Scoliosis of the Spine, Sickle Cell or Asthma? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever suffered from a heat-related illness? (Heat Exhaustion or Heat Stroke) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you missing any major body organ? (Eye, ear, lung, kidney, spleen, testicle, ovary, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has a medical doctor ever advised you NOT to participate in athletic related activities? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you been hospitalized for any reason in the past year? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you take any medications on a regular basis for a medical condition? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please provide information to any question that you answered YES to.

CONSENT FORM

I, The Parent/Guardian do hereby give my permission for the above child to participate in the sports program at Lafayette County School System. As the Parent/Guardian, I will take responsibility for cost due to athletic injury while participating in the sport of choice. Due to the rising cost of insurance premiums, the Lafayette County School District no longer carries any insurance to cover athletic injuries.

Parent Signature: _____ **Date:** _____

WAIVER FORM

The above athlete has opted to waive their rights under the US Department of Health and Human Resources guidelines. The above mentioned athlete is aware that this waiver can be revoked by submitting in writing the intention of doing so. By signing this release, the athlete allows the sharing of medical information between his/her medical provider, Endurance Physical Therapy, the coaches of athlete's sport, and school administration.

Parent Signature: _____ **Date:** _____

Athlete Signature: _____ **Date:** _____

TREATMENT FORM

In the event of an emergency, I grant permission for the above child to receive any medical treatment deemed necessary to Endurance Physical Therapy and _____.

Parent/Guardian: _____ **Card Holder Name and Date of Birth:** _____

Parent/Guardian Phone Number(s): _____

Group Number: _____ **ID Number of Insurance:** _____

FOR PHYSICIAN ONLY. DO NOT WRITE IN THE FOLLOWING SECTION.

| | | | | | | | | | | | |
|-----------------------------------|--------------------------|--------------------------|----------|--|-----|------------------------------|---|-------|---------------------|-----|--|
| Height: _____ | ft | _____ | in | Weight: _____ | lbs | Blood Pressure: _____ | / | _____ | Pulse: _____ | bpm | |
| GENERAL | NORMAL | ABNORMAL | COMMENTS | PHYSICIAN RECOMMENDATIONS FROM THIS LIMITED SCREENING | | | | | | | |
| Ear, Nose Throat | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> CLEARED - NO RESTRICTIONS | | | | | | | |
| Chest, Heart, Lungs & Abdomen | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> CLEARED - After evaluation/rehabilitation for _____ | | | | | | | |
| MUSCULOSKELETAL | | | | | | | | | | | |
| Cervical Neck & Spine | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> NOT CLEARED - Reason _____ | | | | | | | |
| Upper Extremities | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | | | | |
| Lower Extremities | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | | | | |
| General Flexibility | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | | | | |
| PHYSICIAN SIGNATURE: _____ | | | | | | EXAM DATE: _____ | | | | | |

MISSISSIPPI HIGH SCHOOL ACTIVITIES ASSOCIATION, INC.
CONCUSSION INFORMATION FORM
(Required by MHSAA Annually)

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. In other words, even a “ding” or a bump on the head can be serious. You cannot see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

- | | |
|---|--|
| <ul style="list-style-type: none">• Headaches• “Pressure in head”• Nausea or vomiting• Neck pain• Balance problems or dizziness• Blurred, double or fuzzy vision• Sensitivity to light or noise• Feeling sluggish or slowed down• Feeling foggy or groggy• Drowsiness• Change in sleep patterns | <ul style="list-style-type: none">• Amnesia• “Don’t feel right”• Fatigue or low energy• Sadness• Nervousness or anxiety• Irritability• More emotional• Confusion• Concentration or memory problems (forgetting game plays)• Repeating the same question/comment |
|---|--|

Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays in-coordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can’t recall events prior to hit
- Can’t recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is key to a student-athlete’s safety.

MHSAA Concussion Policy:

- An athlete who reports or displays any symptoms or signs of a concussion in a practice or game setting should be removed immediately from the practice or game. The athlete should not be allowed to return to the practice or game for the remainder of the day regardless of whether the athlete appears or states that he/she is normal.
- The athlete should be evaluated by a licensed, qualified medical professional working within their scope of practice as soon as can be practically arranged.
- If an athlete has sustained a concussion, the athlete should be referred to a licensed physician preferably one with experience in managing sports concussion injuries.
- The athlete who has been diagnosed with a concussion should be returned to play only after full recovery and clearance by a physician. Recovery from a concussion, regardless of loss on consciousness, usually take 7-14 days after resolution of all symptoms.
- Return to play after a concussion should be gradual and follow a progressive return to competition. An athlete should not return to a competitive game before demonstrating that he/she has no symptoms in a full supervised practice.
- Athletes should not continue to practice or return to play while still having symptoms of a concussion. Sustaining an impact to the head while recovering from a concussion may cause Second Impact Syndrome, a catastrophic neurological brain injury.

Remember, it is better to miss one game than to miss the whole season.

I have reviewed this information on concussions and am aware that a release by a medical doctor is required before a student may return to play under this policy.

Student-Athlete Name Printed

Student-Athlete Signature

Date

Parent Name Printed

Parent Signature

Date