



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 |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Sudden Death |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease / High Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Trait / Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Sudden Infant Death |
| <input type="checkbox"/> | <input type="checkbox"/> | Drowning or near drowning |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker or implantable defibrillator |

Please explain any "Yes" _____

- | Yes | No | Condition |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertrophic cardiomyopathy |
| <input type="checkbox"/> | <input type="checkbox"/> | Marfan syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | Arrhythmogenic right ventricular cardiomyopathy |
| <input type="checkbox"/> | <input type="checkbox"/> | Long QT syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | Short QT syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | Brugada syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | Catecholaminergic polymorphic ventricular tachycardia |

Please explain any "Yes" _____

ATHLETE'S ORTHOPAEDIC HISTORY

Has the athlete had any of the following injuries?

- | Yes | No | Condition |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Concussion |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder L / R |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow L / R |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee L / R |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot L / R |
| <input type="checkbox"/> | <input type="checkbox"/> | Pinched Nerve |
| <input type="checkbox"/> | <input type="checkbox"/> | Transient Quadriplegia / Stenosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any numbness, tingling or weakness in your arms or legs after being hit or falling? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been unable to move both arms and both legs after being hit or falling? |

Date _____

- | Yes | No | Condition |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Injury / Stinger |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm / Wrist / Hand L / R |
| <input type="checkbox"/> | <input type="checkbox"/> | Back |
| <input type="checkbox"/> | <input type="checkbox"/> | Thigh L / R |
| <input type="checkbox"/> | <input type="checkbox"/> | Lower Leg L / R |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle L / R |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest |

Date _____

Previous Surgeries: _____

ATHLETE'S MEDICAL HISTORY

Has the athlete had any of these conditions?

- | Yes | No | Medical |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Single Testicle |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Organ Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous Surgeries |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath with exercise |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (circle): Type I Type II |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Overnight in hospital |

Yes No Medical

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid weight loss / gain |
| <input type="checkbox"/> | <input type="checkbox"/> | Take supplements / vitamins |
| <input type="checkbox"/> | <input type="checkbox"/> | Heat related problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual irregularities |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Mononucleosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Enlarged Spleen |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Trait / Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision loss: significant loss of vision in one eye |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies (Food, Drugs) |

Yes No Cardiac

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Previously diagnosed or tested positive for COVID-19 Date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizzy or Fainting with Exercise |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease / Marfan's / Kawasaki's |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Shortness of Breath w/Exercise |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 _____, 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 _____
DO NOT FOLD FORM

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

Typed or Printed Name of Physician _____

SIGNATURE OF PHYSICIAN _____

M.D.