

2022-2023 STUDENT PARTICIPATION CLEARANCE FORM

I hereby give consent for my child, _____
_____, to participate in the
_____ School or School District's athletic and
activities programs during the 2022-2023 school year. I agree to abide by
the rules and regulations of my school district and its governing body, the
Mississippi High School Activities Association.

I hereby authorize and give permission for emergency medical treatment
to be rendered for and on behalf of my child,
_____, for any
injury received while participating in any supervised school activity. This
authorization includes, but is not limited to, any treatment deemed
necessary by certified personnel, physicians, hospital emergency room
physicians and hospitals.

I hereby release the _____ School District and all
school personnel for any and all liability associated with such necessary
treatment.

I hereby acknowledge that health and accident insurance is recommended
for participation in all organized sports and activities and further certify that
my child is covered under the health and accident program listed below.

School Day Insurance: _____

Policy #: _____

Other Insurance: _____

Policy #: _____

In addition, I assume any expenses for liability not covered by the
insurance policy above for injury received by the above named student
while participating in sports and school activities. I accept full
responsibility for medical and hospital expenses and any other related
expenses and do hereby hold harmless the _____

School District and the Board of Trustees, their agents or assignees, of responsibility for any such injury or expenses and waive any and all claims which may arise against them. I realize that participation in organized sports and activities involves the potential for injury, sometimes severe enough to result in total disability, paralysis, or death.

I give the Mississippi High School Activities Association and its assigns, licensees and legal representatives the irrevocable right to use any picture or image or sound recording of the student in all forms and media and in all manners, for any lawful purposes. In addition, I consent to the disclosure, by my child's/ward's school, to the MHSAA, upon its request, of all records relevant to his/her eligibility and participation including, but not limited to, his/her records relating to enrollment and attendance, academic standing, age, discipline, residence and physical fitness.

The Student Participation Clearance Form is required for all students to participate in MHSAA athletic and activity programs.

Parent/Legal Guardian: _____

Phone#: _____

Cell #: _____

Signature: _____ Date: _____ (valid

365 from this date)

DO NOT FOLD FORM
MISSISSIPPI ATHLETIC PRE-PARTICIPATION FORM
Please Print

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"	Yes	No	Condition	Please explain any "Yes"
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hypertrophic cardiomyopathy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sudden Death	_____	<input type="checkbox"/>	<input type="checkbox"/>	Marfan syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmogenic right ventricular cardiomyopathy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease / High Pressure	_____	<input type="checkbox"/>	<input type="checkbox"/>	Long QT syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	Short QT syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait / Anemia	_____	<input type="checkbox"/>	<input type="checkbox"/>	Brugada syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sudden Infant Death	_____	<input type="checkbox"/>	<input type="checkbox"/>	Catecholaminergic polymorphic ventricular tachycardia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drowning or near drowning	_____				
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or implantable defibrillator	_____				

ATHLETE'S ORTHOPAEDIC HISTORY

Has the athlete had any of the following injuries?

Yes	No	Condition	Date	Yes	No	Condition	Date
<input type="checkbox"/>	<input type="checkbox"/>	Concussion	_____	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury / Stinger	_____
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Arm / Wrist / Hand L / R	_____
<input type="checkbox"/>	<input type="checkbox"/>	Elbow L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Back	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hip	_____	<input type="checkbox"/>	<input type="checkbox"/>	Thigh L / R	_____
<input type="checkbox"/>	<input type="checkbox"/>	Knee L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Lower Leg L / R	_____
<input type="checkbox"/>	<input type="checkbox"/>	Foot L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ankle L / R	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pinched Nerve	_____	<input type="checkbox"/>	<input type="checkbox"/>	Chest	_____
<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?					

Previous Surgeries: _____

ATHLETIC MEDICAL HISTORY

Has the athlete had any of these conditions?

Yes	No	Medical	Yes	No	Medical	Yes	No	Cardiac
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Medications _____
<input type="checkbox"/>	<input type="checkbox"/>	Single Testicle	<input type="checkbox"/>	<input type="checkbox"/>	Rapid weight loss / gain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Take supplements / vitamins	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Organ Loss	<input type="checkbox"/>	<input type="checkbox"/>	Heat related problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Infection
<input type="checkbox"/>	<input type="checkbox"/>	Previous Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual irregularities	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath with exercise	<input type="checkbox"/>	<input type="checkbox"/>	Recent Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat
<input type="checkbox"/>	<input type="checkbox"/>	History of Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Spleen	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy or Fainting with Exercise
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (circle): Type I Type II	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait / Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease / Marfan's / Kawasaki's
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Vision loss: significant loss of vision in one eye	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Shortness of Breath w/Exercise
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Food, Drugs) _____	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain or Tightness w/Exercise
<input type="checkbox"/>	<input type="checkbox"/>	Overnight in hospital						

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 _____

SIGNATURE OF PARENT (or Patient if 18 or older) _____

DO NOT FOLD FORM

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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

_____, M.D.
Typed or Printed Name of Physician

SIGNATURE OF PHYSICIAN

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:

- | | |
|-----------------------------------|-------------------------------------|
| • Headaches | Amnesia |
| • "Pressure in head" | "Don't feel right" |
| • Nausea or vomiting | Fatigue or low energy |
| • Neck pain | Sadness |
| • Balance problems or dizziness | Nervousness or anxiety |
| • Blurred, double or fuzzy vision | Irritability |
| • Sensitivity to light or noise | More emotional |
| • Feeling sluggish or slowed down | Confusion |
| • Feeling foggy or groggy | Concentration or memory problems |
| • Drowsiness | (forgetting game plays) |
| • Change in sleep patterns | 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 incoordination
- 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

(Continued on next page)

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