MSHSAA PARTICIPATION CERTIFICATE – Physician/Parent/Student

This card is to be completed prior to the first practice session. It contains vital information in case of injury. This care should accompany this athlete to all practices and contests!!! It also should be put in the school's central file during the off-season.

Section 1: **ATHLETES APPLICATION AND PERSONAL INFORMATION**

Name ______________________________ Male _______ Female _____

Address ____________________ City/Zip ______________ Age ________ Birth Date _____/_____/____

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them. I also understand that if I do not meet the citizenship standards set by the school of if I am ejected from an interscholastic contest because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verily that it is correct and complete.

Signed by Student ______________________________ Date ________________

Section 2: **PARENT PERMISSION AND AUTHORIZATION FOR TREATMENT**

We hereby give our consent for the above student to represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in cas of accident or injury whether it be enroute to or from another school or during practice or an interscholastic contest, and we hereby agree to hold the school district of which this school is a port, its employees, agents, representative, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school.

If we cannot be reached and in the event of an emergency, we also give consent for the school to obtain through a physician or hospital of its choice, such medical care as is reasonably necessary for the welfare of the student, if he/she is injured in the course of school athletic activities. We understand that the school may not provide transportation to all events, and permit / do not permit (CIRCLE ONE) my child to drive his/her vehicle in such a case.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are know to us which may affect this athlete's performance or treatment, and we certify that it is correct and complete.

The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he/she has basic athletic insurance coverage. Our son/daughter is covered by basic accident insurance for the current school year with -

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(Name of Insurance Company) (Policy Number)

Signatures of Parents or Guardians
(All parents or guardians must sign) ______________________________

______________________________ Date ________________

Section 3: EMERGENCY INFORMATION

Parent's Name ______________________________ Phone ________________

Doctor's Name ______________________________ Phone ________________

Doctor's Address ______________________________ City/Zip ________________

Section 4: PHYSICIANS EXAMINATION RECORD

Pulse________ Rhythm ________ Blood Pressure ________________ Weight __________ Height ________

Heart________ Describe any abnormality ______________________________
(check)

Eyes/Ears/Nose/Throat ________ Describe any abnormality ______________________________
(Check)

Abdomen ________ Describe any abnormality______________________________
(Check)

Hernia No _____Yes _______ Genitalia ________________ Reflexes ________________

Extremities and back. Please indicate any history of orthopaedic defect(s) ______________________________

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Urinalysis ________ (If indicated) Blood Count__________ (if indicated) Date of last Tetanus immunization ___________

I certify that I have on this date examined the above student and from this limited examination, he/she is approved to participate in supervised athletics. (Physician should sign only if approved.)

Date____/______/_____ Signed ______________________________
Physician

TO BE COMPLETED IN DUPLICATE