

MISSISSIPPI SCHOOL FOR MATHEMATICS AND SCIENCE

15. Do you have only one of any paired organ (eyes, kidneys, testicles, ovaries)? . . . _____
16. Have you had a medical problem or injury since your last physical exam? _____
17. When was your last tetanus shot? _____

PART II: MEDICAL HISTORY

Student Full Name: _____ Date of birth: _____
LAST FIRST MIDDLE

Race _____ Gender _____ Grade _____

Parent(s)/Legal Guardian(s): _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PERSONAL HISTORY (check where applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Ear, Nose, Throat Problems | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> ADHD/Learning Disability | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia/Blood Disorder | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures/Sprains | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Frequent Indigestion/GERD | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Head injury/concussion | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Counseling/Psychotherapy | <input type="checkbox"/> Hernia | <input type="checkbox"/> Thyroid/Hormone Problem |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Congenital Heart Problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Unusual Childhood Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Intestinal/Digestive Problem | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | FEMALES ONLY: |
| <input type="checkbox"/> Diminishing Hearing | <input type="checkbox"/> Malaria | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Dizziness/Fainting Spells | <input type="checkbox"/> Measles | <input type="checkbox"/> Severe cramps |
| <input type="checkbox"/> Drug Use | <input type="checkbox"/> Migraines | <input type="checkbox"/> Excessive flow |

FAMILY HISTORY (Parents, Siblings, Grandparents) *Check where applicable.*

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sudden Death |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Intestinal Disease | <input type="checkbox"/> Other: (specify) _____ |

Are you under treatment for any medical/emotional condition? (Describe) _____

ALLERGIES *check where applicable*

- | | | |
|--|---|--|
| <input type="checkbox"/> No know allergies | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Food: _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other medication(s): _____ | <input type="checkbox"/> Insect: _____ |
| <input type="checkbox"/> Penicillin | _____ | <input type="checkbox"/> Animal: _____ |
| <input type="checkbox"/> Codeine | _____ | <input type="checkbox"/> Other: _____ |

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MEDICATIONS currently being used: *check where applicable*

- None
- Vitamins: _____
- Herbal supplements: _____
- Oral Contraceptives: _____
- Prescription Medications: _____
- Over the counter: _____

The pre-participation questionnaire and examination is limited and designed to identify common conditions or infirmities that would limit or prevent a student from participating in athletics or typical physical activities associated with our residential programming. The examination is NOT meant to be comprehensive and may not detect some types of latent or hidden medical conditions. All students should receive a periodic comprehensive medical examination and prompt treatment of illnesses and/or injuries.

I hereby state that, to the best of my knowledge, my answers to the above questions are correct. Furthermore, I give permission for this pre-participation physical examination of my child or ward.

Signature of student: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

PART III: PHYSICAL EXAM - TO BE COMPLETED BY PHYSICIAN:

PART III: PHYSICAL EXAM MUST BE FILLED OUT IN ITS ENTIRETY. Please review the student's history as provided on earlier pages of this document. Please attach a separate letter detailing the medical history and management plan for any serious or chronic illness not addressed on this form.

Height: _____ ft _____ in Weight: _____ lbs. BP: _____/_____ Pulse: _____

Skeletal Size: Small _____ Medium _____ Large _____ ExLarge _____ BMI _____

Laboratory: Hemoglobin or Hematocrit: _____ Urine: _____

(Circle One) Value SpGr Protein Sugar

ATTACH A COPY ON THE DOCTOR'S LETTERHEAD ON ONE OF THE FOLLOWING RESULTS TO BE TAKEN AFTER MAY 1, 2011:

Acid Fast Smear First Morning Sputum Tuberculin Skin Test

IMMUNIZATION HISTORY:

	DPT	MMR	Polio	HepB	Meningitis	Varicella	HPV
Current							
Not Current							
Not applicable							

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EARS: Is hearing normal? YES

NO

Are drums intact? YES

NO

	Normal	Abnormal Findings
Skin		
Head, Face, Neck		
Nose & Sinuses		
Mouth & Throat		
Teeth		
Lungs & Chest		
Heart		
Vascular System		
Abdomen		
Endocrine		
Spine		
Neurologic		
Musculoskeletal (ROM, Strength, etc.)		
• Neck		
• Spine (scoliosis)		
• Shoulders		
• Elbows		
• Wrists		
• Arms/hands		
• Hips		
• Thighs		
• Knees		
• Ankles		
• Feet		
• Other		

Male students:

Hernia

Normal

Abnormal

Genitalia

Normal

Abnormal

Female Students:

Breasts

Normal

Abnormal

Pelvic

Normal

Abnormal

Is there or has there been any physical or emotional problem that is likely to interfere with this student's adjustment to residential life or participation in physical activity? NO YES

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If "YES", please explain: _____

Please itemize any regular prescription medications or reoccurring treatment needs of this student (allergy shots, counseling, etc.) which must be continued while enrolled at the Mississippi School for Mathematics and Science:

Please Print/Stamp

Physician's Name	
Street Address	
City, State, Zip Code	
Telephone & Fax	

PHYSICIAN'S STATEMENT:

I certify that I am a **licensed** physician or family nurse practitioner and that I have examined this student. At the time of examination, no physical condition was detected which would reasonably be anticipated to render this student unfit to engage in intramurals, MHSAA athletics, or moderately strenuous exercise, except as noted below.

RESTRICTIONS:

Additional recommendations regarding health/wellness:

Signature of Physician: _____ Date: _____