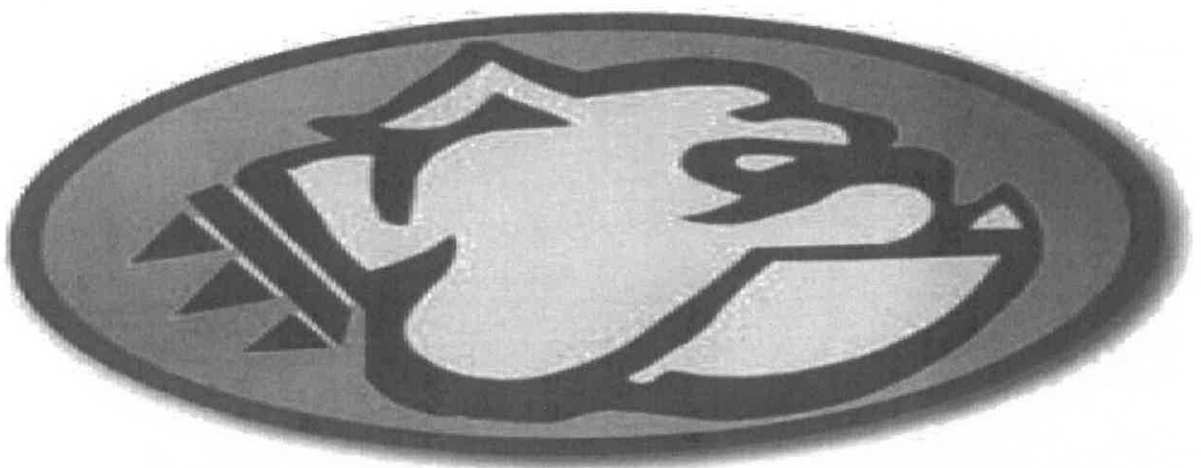


# MMS ATHLETICS TRYOUT REQUIREMENTS

The following are required for tryouts for any sport at MMS:

- Dragonfly Account
- Pre-participation Physical Form (Front side of AHSAA approved Physical Form)
- Physical Form (Back side of AHSAA approved Physical Form)
- Participant Agreement (digitally signed in Dragonfly)
- Concussion Form (digitally signed in Dragonfly)
  
- See Coach Matthews for Blank Physical Forms and a "How To" Form on creating a Dragonfly Account

*\* PROVIDED IN PACKET \**





# GET STARTED WITH DRAGONFLY



DragonFly makes sports and activities more organized with easy-to-use digital forms, health records and team communication tools.



## PARENTS & STUDENTS

- 1 Visit [dragonflymax.com](http://dragonflymax.com) and click the 'Log In/Sign Up' button.
- 2 Click 'Sign Up for Free' then follow the prompts to create your Parent account with your own email address.  
*Note: please do not create an account with your child's name or contact information -- you will get the chance to add your child soon!*
- 3 Verify your account with the verification ID sent to your email address.
- 4 Click 'Connect to your school' to select 'Parent' as your role and search for your child's school. 2025 - 2026
- 5 After selecting your child's school, click 'Join' to request access. An administrator at your school will approve your request.
- 6 Click 'Set up your children' and follow the prompts to add your kid(s) and fill out their participation forms.



## ATHLETIC DIRECTORS, COACHES & SCHOOL ADMINISTRATORS

- 1 Visit [dragonflymax.com](http://dragonflymax.com) and click the 'Log In/Sign Up' button.
- 2 Click 'Sign Up for Free' to create your account with your school email address.
- 3 Verify your account with the verification ID sent to your email address.
- 4 Click the 'Get Started' button to select your role and search for your school.
- 5 After selecting your school, click 'Join' to request access. You will see a list of administrators at your school who can approve your request. If you're the first person to request access to your school, a member of the DragonFly team will verify your role and approve your request.

Upload: Physical (Front & Back), Ins Card. Digitally Sign: Participation, Concussion

### PREFER TO USE A MOBILE DEVICE?

Visit [dragonflymax.com](http://dragonflymax.com) in your mobile browser and follow the steps above.

PLEASE SAVE YOUR LOGIN WHEN CREATING ACCOUNT!



**ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION**  
**Preparticipation Physical Evaluation Form**  
**Revised 2018**

*Revised 2018*

**History**  
 Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Date of birth \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_ Phone \_\_\_\_\_  
 Sport \_\_\_\_\_

Explain "Yes" answers below:	Yes	No
1. Has a doctor ever restricted/denied your participation in sports?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized or spent a night in a hospital? Have ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you presently taking any medications or pills (prescription or over-the-counter)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain or discomfort in your chest during or after exercise? Do you tire more quickly than your friends during exercise? Have you ever had high blood pressure? Have you ever been told that you have a heart murmur, high cholesterol, or heart infection? Have you ever had racing of your heart or skipped heartbeats? Has anyone in your family died of heart problems or a sudden death before age 50? Does anyone in your family have a heart condition? Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a head injury or concussion? Have you ever been knocked out or unconscious? Have you ever had a seizure? Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had heat or muscle cramps? Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have trouble breathing or do you cough during or after activity? Do you take any medications for asthma (for instance, inhalers)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had any problems with your eyes or vision? Do you wear glasses or contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you had a medical problem or injury since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been told you have sickle cell trait? Has anyone in your family had sickle cell disease or sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? <input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Finger <input type="checkbox"/> Thigh <input type="checkbox"/> Shin <input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>
17. When was your first menstrual period? _____ When was your last menstrual period? _____ What was the longest time between your periods last year? _____		
Explain "Yes" answers: _____ _____ _____		

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.  
 Signature of athlete \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of parent/guardian \_\_\_\_\_

**DUPLICATE AS NEEDED**

# Preparticipation Physical Evaluation

Rule 1, Sec. 14 — In order for a student to be eligible for interscholastic athletics, there must be on file in the Superintendent's or Principal's office a current physician's statement certifying that the student has passed a physical exam, and that in the opinion of the examining physician (M.D. or D.O.) the student is fully able to participate in interscholastic athletics (Grade s 7-12). The AHSAA Physicians Certificate (Form 5 Rev. 2018) must be used. A physical exam will satisfy the requirement for one calendar year through the end of the month from the date of the exam. For example, a physical given on May 5, 2021, will satisfy the requirement through May 31, 2022.

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## Physical Examination

<b>LIMITED</b>	Height _____ Weight _____ BP _____ / _____ Pulse _____		
	Vision R 20 / _____ L 20 / _____ Corrected: <input type="radio"/> N <input type="radio"/>		
		Normal	Abnormal Findings
	Cardiovascular		
	Pulses		
	Heart		
	Lungs		
	Skin		
	E.N.T.		
	Abdominal		
	Genitalia (males)		
	Musculoskeletal		
	Neck		
	Shoulder		
	Elbow		
	Wrist		
	Hand		
	Back		
	Knee		
	Ankle		
Foot			
Other			

Clearance:

- A. Cleared  
 B. Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 C. Not cleared for:
  Collision
  Contact
  Noncontact
  Strenuous
  Moderately strenuous
  Nonstrenuous

Due to: \_\_\_\_\_

Recommendation: \_\_\_\_\_

Name of physician \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, M.D. or D.O.

(Form must be signed and dated by the attending physician.)