

U – High Athletic Forms 2014 – 2015

- 1. LHSAA Athletic Participation Parental Permission Form**
- 2. Athlete Information and Medical Consent 2014 – 2015**
- 3. Insurance Form**
- 4. LHSAA Substance Abuse/Misuse Contract and Consent Form**
- 5. Travel Form**
- 6. Concussions Awareness Form**
- 7. Medical History-Medical Exam Form**

**Please type your information directly to the forms.
Then, print the packet and return the signed forms.**

Louisiana High School Athletic Association

Athletic Participation/Parental Permission Form

*This form must be completed and signed **each year** prior to a student's participation in an athletic contest and shall be kept on file with the school. This form is subject to inspection by the LHSAA Rules Compliance Team.*

PART I: To be completed and signed by student-athlete (Please Print)

Name: (Last, First, Middle) _____ School Year: _____

Home Address: _____ Parents' Home Address: _____

City: _____ Zip: _____ City: _____ Zip: _____

Date of Birth: _____ Date of Last Physical Exam: _____

I entered ninth grade in _____ (month and year). Last semester/year I attended _____
_____ School.

I certify the preceding information is correct, I have read the summary of LHSAA eligibility rules below and I am in compliance with these standards.

Date: _____ Student's Signature: _____

Telephone No: _____

ARE YOU ELIGIBLE?

As a student athlete in an LHSAA school, you must meet the following rules to be eligible for interscholastic athletic competition:

| <u>RULE</u> | <u>COMMENTS</u> |
|---------------------------------------|---|
| BONA FIDE STUDENT | You must be counted as a student on the daily attendance records at your school. Attendance in one class makes you a student at that school. |
| ENROLLMENT | You must attend class during the first 11 school days of the first semester or you will be ineligible for the first 30 school days. |
| AGE | You cannot become 19 years of age prior to September 1 of this year. |
| PROOF OF AGE | You must provide legal proof of age, which meets the provisions of the LHSAA handbook, to your school administrator to be kept on file at school. |
| CONSECUTIVE SEMESTERS | Once you enter the ninth grade, you have eight consecutive semesters to play athletics. (EXCEPTION: Hold-Back Repeat Student – See Rule 1.31.9 of the LHSAA handbook) |
| SCHOLASTIC | <p>For regular education high school students at the end of the first semester you must pass at least six subjects in all subjects taken.</p> <p>At the end of the year and prior to the next school year, you must have earned at least six units with an overall "C" average as determined by the LEA in all units taken.</p> <p>All seniors must take at least four (4) subjects each semester.</p> <p>Special education students must consult the school principal, athletic director, or coach for scholastic information.</p> |
| RESIDENCE AND SCHOOL TRANSFERS | Upon entering high school for the first time, a student shall have the choice to attend any member school located in the parish in which the student resides with his/her parent(s)/guardian(s) or any other household with whom the student has been residing for the past calendar year and be immediately eligible unless an applicable exception applies. A transfer to another member school in the same parish will render the student ineligible for one calendar year. |

(OVER)

| | |
|---|--|
| UNDUE INFLUENCE | If you have been recruited to the school for athletic purposes, you will remain ineligible as long as you attend that school. |
| AMATEUR | You cannot play high school athletics if you lose your amateur status. |
| INDEPENDENT TEAM | In certain sports you cannot play on a school team and an independent team during the same sport season. |
| MEDICAL EXAMINATION | You must annually pass a physical examination given by a licensed physician/nurse practitioner that is in collaboration with a licensed physician or a licensed physician's assistant under the supervision of a licensed physician and complete an LHSAA Medical History Evaluation form prior to participating. |
| ATHLETIC PARTICIPATION/ PARENTAL PERMISSION FORM | A school shall be required to have this form completed and signed every year prior to a student's participation in LHSAA athletics at the school. |
| SUBSTANCE ABUSE/MISUSE CONTRACT & CONSENT FORM | A school shall only be required to have this form completed and signed prior to the first time a student participates in LHSAA athletics at the school. |
| SUSPENDED AND INELIGIBLE STUDENTS | Cannot participate in any interscholastic contest on any team at any school at any level. |

LHSAA ELIGIBILITY RULES APPLY TO STUDENT ATHLETES ON ALL TEAMS AT ALL LEVELS OF PLAY AT ALL LHSAA SCHOOLS

Eligibility to participate in interscholastic athletics is a privilege you earn by meeting standards outlined on this form and other regulations and policies set by the LHSAA and your school. If you have questions or do not fully understand an eligibility rule, check with your principal, athletic director or coach. By following the intent and spirit of the rules, you can help prevent violations which may penalize you, your team and/or your school.

ONE INELIGIBLE STUDENT MAY DISQUALIFY YOUR WHOLE TEAM – KNOW YOUR ELIGIBILITY RULES

PART II – PARENTAL PERMISSION - To be completed and signed by parent

I have read and reviewed the general requirements for high school athletic eligibility on this form and have discussed these requirements with my student athlete. I understand additional questions /explanations and specific circumstances should be directed to my student's principal, athletic director or coach.

I certify the parents' home address, on the reverse, is my sole bona fide residence and will notify the school principal immediately of any change in residence, since such a move may alter the eligibility status of my student athlete. All other information on the reverse is also accurate and current.

I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/ athletic director/principal of his/her school. Additionally, I give the LHSAA or it representative(s) permission to review my child's scholastic records and all required eligibility forms.

If the medical status of my child changes in any significant manner after he/she passes his/her physical examination, I will notify his/her principal of the change immediately.

I hereby give my consent and approval for the student named on this form **to participate in any** of the following LHSAA sports:

| | | |
|---------------|--------------|-----------------|
| BASEBALL | GOLF | SWIMMING |
| BASKETBALL | GYMNASTICS | TENNIS |
| BOWLING | POWERLIFTING | TRACK AND FIELD |
| CROSS COUNTRY | SOCCER | VOLLEYBALL |
| FOOTBALL | SOFTBALL | WRESTLING |

Date: _____ **Parent's Signature:** _____

(Print Name) _____

Telephone No: _____

Louisiana State University Laboratory School

Athlete Information and Medical Consent 2014 - 2015

1. Athlete Information

- a. NAME:
- b. GRADE:
- c. DATE OF BIRTH:
- d. SPORTS PLAYED:
- e. CELL PHONE NUMBER:
- f. Parents/Guardians Name and Cell Phone Numbers:
- g. Primary Insurance:

2. Medical Information – Please be as SPECIFIC as possible!

- a. Please list ALL medications and supplements currently taken by the student athlete:

- b. Allergies:
- c. Please list ALL medical conditions or information (example: asthma, heart conditions, diabetes, epilepsy, etc):
- d. Does the student athlete require an inhaler, Epi-Pen, insulin, etc. ? If so, please have a copy of the necessary medication given to the head athletic trainer. ☐
- e. Does the student athlete have a history of heat related muscle cramps, concussions, dislocations, etc? ☐

3. Please list and describe in detail any other important medical information that the athletic training staff needs to know in order to effectively treat the student athlete:

4. MEDICATION RELEASE: Please sign indicating that the athletic training staff at LSU Lab School is allowed to dispense over the counter medication to your student athlete as needed. Please understand that failure to sign this release will render the athletic training staff unable to give medication of any type to your child.

- A. I, _____, give permission for my child to be given medications at the discretion of the athletic training staff or team physician. I understand that I am responsible for communicating any and all allergies, restrictions, and/or concerns to the medical staff (see below).

B. NOTES/COMMENTS:

TO: Parents of Athletes

FROM: Wade Smith, Director

Please be informed that University High School does not carry insurance for students participating in athletics or other activities at University High School. Parents provide this insurance for their children through their own private arrangement or through participation in the group insurance program provided by a private agency for the school. At the present time, MEGA Life Health Insurance company is the group insurance agency for the school.

In order for a student of University High School to participate in athletics at University High School, it is absolutely necessary that he/she be covered by an insurance program provided for by the family. In this connection, please give us the information requested below and sign this form indicating that you understand this communication and have accepted the responsibilities herein stated.

1. I wish to enroll my child in MEGA Life and Health Insurance Company. (See enclosed brochure);

or

2. My son/daughter is covered by needed medical attention, treatment, hospitalization, etc. resulting from accidental injuries incurred while participating in school athletics including football by:

Insurance Company: _____

Type of Policy: _____

Policy Number: _____

Student's Name: _____

Parent/Guardian Signature: _____

Date: _____

Date received by school: _____

LHSAA SUBSTANCE ABUSE/ MISUSE CONTRACT AND CONSENT FORM

This form must be completed and signed and kept on file with the school and is subject to inspection by the LHSAA Rules Compliance Team.

As an LHSAA athlete, I, _____, agree to avoid the abuse or misuse of legal or illegal substances, including anabolic steroids and other performance enhancing drugs. I hereby grant permission to be tested for substance abuse/misuse as a participant in any LHSAA sports program. I furthermore agree to cooperate by providing a urine or hair specimen for testing upon the request of my principal. I understand that should my specimen indicate the abuse or misuse of legal or illegal substances, I will be subject to action specified in my School Drug Policy for Student Athletes.

I, _____, parent/guardian of the undersigned student-athlete, individually, and on behalf of my child, do hereby grant permission for and consent to said child being tested for substance abuse/misuse in accordance with his/her School Drug Policy for Student-Athletes and I understand that if any specimen taken from him/her indicates abuse or misuse of legal or illegal substances, including anabolic steroids and other performance enhancing drugs, he/she will be subject to action specified in the School Drug Policy for Student-Athletes for his/her school.

Dated: _____

Student-Athlete

Dated: _____

Parent/Guardian

Notes: Rule 1.10.2 of the LHSAA By-Laws, states that this contract shall remain in effect for the remainder of the student's eligibility. This means the contract only has to be signed once by both the student and his/her parent or guardian but the terms remain in effect for the student's entire high school career.

According to Rule 1.10.3 of the LHSAA By-Laws, without the signature of the student athlete and his/her parent/guardian, the student is ineligible to participate in interscholastic athletic contests at all levels of play in all LHSAA sports at all LHSAA schools until compliance with Rule 1.10.2 is obtained from both parties.

Any student participating in an interscholastic athletic contest(s) without a properly signed contract shall be classified as an ineligible student and both the student and school shall be penalized according to Rule 1.10.3.

Signature of the LHSAA's contract does not necessarily mean the student athlete will be tested. Federal courts have consistently ruled participation in high school athletics is a privilege, not an educational right.

UNIVERSITY LABORATORY SCHOOL ATHLETIC TRAVEL POLICY

Student-athletes who participate in the University Laboratory School's Athletic Program will adhere to the departmental policy for student travel *to and from* athletic events, including but not limited to practices, games, tournaments, meets and matches, according to following stated guidelines:

1. The student-athlete will be responsible for providing his/her own transportation to and from athletic events within a radius of 25 miles around the city of Baton Rouge.
 - a. The student-athlete will drive to and from the event, **OR**
 - b. The student-athlete will ride with another student to and from the event (with signed parental permission), **OR**
 - c. The student-athlete's parent or guardian will provide transportation to and from the event.

2. For events beyond a 25-mile radius around the city of Baton Rouge,
 - a. The parent/guardian will provide transportation for the student-athlete to and from the event, **OR**
 - b. The student-athlete will ride with another adult (21 years or older, with signed parental permission), **OR**
 - c. School officials will make travel arrangements for the entire team. Under these circumstances, all team members must travel to and from the event with the team. Coaches may give student-athletes permission to ride home with their parent.

Clarifications:

*No ULS student-athlete may drive himself/herself or ride in a vehicle driven by another student to any ULS event beyond a 25-mile radius around the city of Baton Rouge.

**Transportation beyond the 25-mile radius around the city of Baton Rouge must be provided by a parent or guardian or another adult (21 years or older, with signed parental permission), or through travel arrangements made by designated school officials.

Any violation of this policy will result in disciplinary action taken by the team coach, the University Laboratory School athletic director and/or the administration of University Laboratory School as deemed appropriate.

PARENTAL AUTHORIZTION FOR STUDENT TRAVEL

I grant permission for **my child,** _____, to participate in the planned activities of the travel required for the sport(s) of:

(Please circle all that apply.)

| | | | | | |
|------------|----------|---------|---------------|------------|--------|
| Basketball | Baseball | Bowling | Cross Country | Golf | Soccer |
| Softball | Swimming | Tennis | Track & Field | Volleyball | |

I grant permission for **my child,** _____, to travel to and from scheduled athletic events in the following manner:

(Please circle all that apply.)

| | | |
|-----|----|--|
| Yes | No | I will provide transportation for my child to and from all University Laboratory School's athletic events. |
|-----|----|--|

| | | |
|-----|----|---|
| Yes | No | My child will drive his/her own vehicle to and from scheduled athletic events within a 25-mile radius around the city of Baton Rouge. |
|-----|----|---|

| | | |
|-----|----|--|
| Yes | No | My child has permission to drive other students to and from scheduled athletic events within a 25-mile radius around the city of Baton Rouge. Exceptions: _____ |
|-----|----|--|

| | | |
|-----|----|---|
| Yes | No | My child has permission to ride with another student to and from scheduled athletic events within a 25-mile radius around the city of Baton Rouge. Exceptions: _____ |
|-----|----|---|

| | | |
|-----|----|---|
| Yes | No | My child has permission to ride with another adult (21 years or older) to and from scheduled athletic events within a 25-mile radius around the city of Baton Rouge. Exceptions: _____ |
|-----|----|---|

| | | |
|-----|----|---|
| Yes | No | My child has permission to ride with another adult (21 years or older) to and from scheduled athletic events beyond the 25-mile radius around the city of Baton Rouge. Exceptions: _____ |
|-----|----|---|

| | | |
|-----|----|---|
| Yes | No | My child has permission to ride on school-provided transportation to and from athletic events beyond a 25-mile radius around the city of Baton Rouge. |
|-----|----|---|

I have carefully read and do hereby agree to the University Laboratory School's athletic travel policy and hold harmless University Laboratory School, the members of the University Laboratory School athletic department, and any designated University Laboratory School's chaperone for any accident, injury or death that may occur during travel to and from an official University Laboratory School's athletic event.

Student-Athlete's Signature

Date

Parent/Guardian's Signature

Date

University Sports Medicine



Concussion Information Sheet – Parents/Guardians and Student – Athletes

Concussion – also known as *Mild Traumatic Brain Injury (MTBI)*, occurs when a direct or indirect blow to the head produces shaking of the brain in the skull, resulting in disruption of axonal connections between the cortex and the midbrain.

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 can’t 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, seek medical attention.

Symptoms may include one or more of the following:

- Headaches
- Nausea or vomiting
- Balance problems or dizziness
- Sensitivity to light or noise
- Feeling foggy or groggy
- Drowsiness
- Amnesia
- Fatigue or low energy
- Sadness
- More emotional
- Confusion
- “Pressure in head”
- Neck pain
- Blurred, double, or fuzzy vision
- Feeling sluggish or slowed down
- Change in sleep patterns
- Confusion
- “Don’t feel right”
- Nervousness or anxiety
- Irritability
- Repeating the same question
- Concentration or memory problems (forgetting game play)

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 lack of coordination
- 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

What can happen if a student – athlete continues to play with a concussion or returns too soon?

Any athlete who displays signs and symptoms of concussion should be removed from play immediately. Continuing to play with a concussion leaves the young 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.

Post Concussive Care

If the athletic training staff or team physician diagnoses a student – athlete with a concussion:

- ➔ Have the athlete go home and REST in a dark or dimly lit environment. Encouraging rest will allow the body to heal itself.
- ➔ Have the athlete discontinue texting, watching TV, computer use, Facebook, etc. These activities require high levels of focus and concentration, which will inhibit the healing process.
- ➔ Unless told otherwise, there is no need to “wake – up” the student athlete every few hours.
- ➔ Have the athlete eat light meals only for a few days so as not to aggravate any symptoms of nausea or vomiting.
- ➔ If, upon arrival at home, or during the night, the student athlete reports or exhibits a WORSENING or DETERIORATION of symptoms, seek medical attention, as well as call Melissa (Head Athletic Trainer) who can help coordinate an appropriate plan of care.
- ➔ Tylenol (acetaminophen) ONLY for headache and pain. Ice bags may be used for comfort as needed.
- ➔ If headache and inability to concentrate are severe, athlete may benefit from staying home from school (at parent/guardian’s discretion).
- ➔ Keep strong lines of communication with athletic training staff so that instructions and clearance for return to play, school, etc. can be given.
- ➔ Follow all instructions given by the athletic training staff.

Upon clearance from team physician, the student athlete will be closely monitored by the athletic training staff and given a guided, slow return to play protocol to ensure optimal safety:

- ➔ Evaluation by Team Physician or Certified Head Athletic Trainer
- ➔ Removal from practice/competition
- ➔ Daily monitoring by Certified Head Athletic Trainer and/or Team Physician
- ➔ Completion of Graded Systems Checklist
- ➔ ImPact Testing or neuropsychological screening
- ➔ Possible referral to Neurologist and/or possible radiographic evaluation
- ➔ Gradual Return – to – Play

University Sports Medicine



QUESTIONS OR CONCERNS:

All questions and concerns regarding concussion protocol can be directed to Melissa Sorrells, Head Athletic Trainer at University High School! Remember, it's better to miss one game than the entire season!!

Melissa A. Sorrells, M.S., ATC, PES, CES

Melissa A. Sorrells, MS, ATC, PES, CES

Msorre2@lsu.edu : Email

(225) 578 – 3221: Office

(985) 502 – 4297: Cell

(225) 578 – 3326: Fax

Parents/Guardian:

I have read and understood the Concussion information that has been provided to me. I plan to discuss this information with my student athlete. I understand that if I have questions or concerns at any time, I am to call the head athletic trainer at University High School.

(Parent/Guardian Printed Name)

(Parent/Guardian Signature)

(Date)

Student – Athlete:

I have read, discussed, and understood the Concussion information that was provided to me. I asked questions about those things which I did not understand. I know that if I am feeling or reporting any signs or symptoms of a possible concussion, to inform my coach, athletic trainer, and parent and that failure to do so could be detrimental to my health.

(Student – Athlete Printed Name)

(Student – Athlete Signature)

(Date)

LHSAA MEDICAL HISTORY EVALUATION

IMPORTANT: This form must be completed annually, kept on file with the school, & is subject to inspection by the Rules Compliance Team.

Please Print

Name: _____ School: _____ Grade: _____ Date: _____
 Sport(s): _____ Sex: M / F Date of Birth: _____ Age: _____ Cell Phone: _____
 Home Address: _____ City: _____ State: _____ Zip Code: _____ Home Phone: _____
 Parent / Guardian: _____ Employer: _____ Work Phone: _____

FAMILY MEDICAL HISTORY: Has any member of your family under age 50 had these conditions?

| Yes | No | Condition | Whom | Yes | No | Condition | Whom | Yes | No | Condition | Whom |
|--------------------------|--------------------------|----------------------|-------|--------------------------|--------------------------|--------------------------|-------|--------------------------|--------------------------|----------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack/Disease | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sudden Death | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Arm / Wrist / Hand L / R | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Trait/Anemia | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | _____ |

ATHLETE'S ORTHOPAEDIC HISTORY: Has the athlete had any of the following injuries?

| Yes | No | Condition | Date | Yes | No | Condition | Date | Yes | No | Condition | Date |
|--------------------------|--------------------------|--------------------------|-------|--------------------------|--------------------------|--------------------------|-------|--------------------------|--------------------------|----------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Head Injury / 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"/> | Elbow L / R | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Arm / Wrist / Hand L / R | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Back | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip L / R | _____ | <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"/> | Chronic Shin Splints | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Ankle L / R | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot L / R | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Severe Muscle Strain | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Pinched Nerve | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest | _____ | Previous Surgeries: | | _____ | | | | | |

ATHLETE MEDICAL HISTORY: Has the athlete had any of these conditions?

| Yes | No | Condition | Yes | No | Condition | Yes | No | Condition |
|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur / Chest Pain / Tightness | <input type="checkbox"/> | <input type="checkbox"/> | Asthma / Prescribed Inhaler | <input type="checkbox"/> | <input type="checkbox"/> | Menstrual irregularities: Last Cycle: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath / Coughing | <input type="checkbox"/> | <input type="checkbox"/> | Rapid weight loss / gain |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Hernia | <input type="checkbox"/> | <input type="checkbox"/> | Take supplements/vitamins |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | Knocked out / Concussion | <input type="checkbox"/> | <input type="checkbox"/> | Heat related problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Single Testicle | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Recent Mononucleosi |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged Spleen |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizzy / Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Trait/Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Organ Loss (kidney, spleen, etc) | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Overnight in hospital |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery | <input type="checkbox"/> | <input type="checkbox"/> | Prescribed EPI PEN | <input type="checkbox"/> | <input type="checkbox"/> | Allergies (Food, Drugs) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Medications _____ | | | | | | |

List Dates for: Last Tetanus Shot: _____ Measles Immunization: _____ Meningitis Vaccine: _____

PARENTS' WAIVER FORM

To the best of our knowledge, we have given true & accurate information & 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 if the examination is provided without expectation of payment, there shall be no cause of action pursuant to Louisiana R.S. 9:2798 against the team volunteer health-care provider and/or employer under Louisiana law.

This waiver, executed on the date below by the undersigned medical doctor, osteopathic doctor, nurse practitioner or physician's assistant and parent of the student athlete named above, is done so in compliance with Louisiana law with the full understanding that there shall be no cause of action for any loss or damage caused by any act or omission related to the health care services if rendered voluntarily and without expectation of payment herein unless such loss or damage was caused by gross negligence. Additionally,

- If, in the judgment of a school representative, the named student-athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary. **Yes** **No**
- I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately. **Yes** **No**
- I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school. **Yes** **No**
- By my signature below, I am agreeing to allow my child's medical history/exam form and all eligibility forms to be reviewed by the LHSAA or its Representative(s) **Yes** **No**

Date Signed by Parent _____ Signature of Parent _____ Typed or Printed Name of Parent _____

II. COMPLETED ANNUALLY BY MEDICAL DOCTOR (MD), OSTEOPATHIC DR. (DO), NURSE PRACTITIONER (APRN) or PHYSICIAN'S ASSISTANT (PA)

| | | | |
|--------------|--------------|----------------------|-------------|
| Height _____ | Weight _____ | Blood Pressure _____ | Pulse _____ |
|--------------|--------------|----------------------|-------------|

GENERAL MEDICAL EXAM :

| | Norm | Abnl |
|-------------|--------------------------|--------------------------|
| ENT | <input type="checkbox"/> | <input type="checkbox"/> |
| Lungs | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdomen | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin | <input type="checkbox"/> | <input type="checkbox"/> |
| Hernia | <input type="checkbox"/> | <input type="checkbox"/> |
| (if Needed) | | |

COMMENTS: _____

OPTIONAL EXAMS:

VISION:
 L: _____ R: _____ Corrected: _____

DENTAL:
 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

ORTHOPAEDIC EXAM :

| | Norm | Abnl |
|-----------------------------|--------------------------|--------------------------|
| I. Spine / Neck | | |
| Cervical | <input type="checkbox"/> | <input type="checkbox"/> |
| Thoracic | <input type="checkbox"/> | <input type="checkbox"/> |
| Lumbar | <input type="checkbox"/> | <input type="checkbox"/> |
| II. Upper Extremity | | |
| Shoulder | <input type="checkbox"/> | <input type="checkbox"/> |
| Elbow | <input type="checkbox"/> | <input type="checkbox"/> |
| Wrist | <input type="checkbox"/> | <input type="checkbox"/> |
| Hand / Fingers | | |
| III. Lower Extremity | | |
| Hip | <input type="checkbox"/> | <input type="checkbox"/> |
| Knee | <input type="checkbox"/> | <input type="checkbox"/> |
| Ankle | <input type="checkbox"/> | <input type="checkbox"/> |

From this limited screening I see no reason why this student cannot participate in athletics.

- [] Student is cleared
 [] Cleared after further evaluation and treatment for: _____
 [] Not cleared for: __contact __non-contact

Printed Name of MD, DO, APRN or PA _____ Signature of MD, DO, APRN or PA _____ Date of Medical Examination _____

This physical expires one year on the last day of the month that it was signed and dated by the MD, DO, APRN or PA.