

IMPORTANT: This form must be completed annually, kept on file with the school, and 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
Heart Attack/Disease
Stroke
Diabetes
Sudden Death
High Blood Pressure
Sickle Cell Trait/Anemia
Arthritis
Kidney Disease
Epilepsy

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

Yes No Condition Date
Head Injury / Concussion
Elbow L / R
Hip L / R
Lower Leg L / R
Foot L / R
Chest
Neck Injury / Stinger
Arm / Wrist / Hand L / R
Thigh L / R
Chronic Shin Splints
Severe Muscle Strain
Shoulder L / R
Back
Knee L / R
Ankle L / R
Pinched Nerve
Previous Surgeries:

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

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

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.

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.

- 1. 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.
2. 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.
3. 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.
4. 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) or the associated medical personnel.

Date Signed by Parent

Signature of Parent

Typed or Printed Name of Parent

Health Care Provider section on page 2

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_ Sport(s): \_\_\_\_\_

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

Height _____	Weight _____	Blood Pressure _____	Pulse _____
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**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"/>

**ORTHOPAEDIC EXAM :**

**I. Spine / Neck**

	Norm	Abnl
Cervical	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>

**II. Upper Extremity**

	Norm	Abnl
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>
Hand / Fingers	<input type="checkbox"/>	<input type="checkbox"/>
Wrist	<input type="checkbox"/>	<input type="checkbox"/>

**III. Lower Extremity**

	Norm	Abn
Knee	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>
Ankle	<input type="checkbox"/>	<input type="checkbox"/>

Health Care Provider notes (if needed): \_\_\_\_\_

- Medically eligible for all sports without restriction
- Medically eligible for certain sports \_\_\_\_\_
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of \_\_\_\_\_
- Not medically eligible pending further evaluation
- Not medically eligible for any sports

This recommendation is from a limited screening.

\_\_\_\_\_  
 Printed Name of MD, DO, APRN or PA

\_\_\_\_\_  
 Signature of MD, DO, APRN or PA

\_\_\_\_\_  
 Date of Medical Examination