

# Hammond High Magnet School Athletics

## Paperwork Checklist

(These are the only acceptable forms)

ATHLETE'S NAME \_\_\_\_\_

(Please print first and last name clearly.)

Check	Item
	1. Current Physical Form - Must be completely filled out with all necessary signatures. *Free North Oaks Physical Day for Hammond High is Thursday, June 2, 2022 (TENTATIVE DATE).
	2. Copy of birth certificate (You do not need another copy if you were on a team last year)
	3. LHSAA Parent Permission Form (2 pages)
	4. North Oaks Authorization to Disclose Drug Screen Results Form
	5. LHSAA Substance Abuse/Misuse Contract & Consent Form
	6. LHSAA Parent & Student Athlete Concussion Statement (completed and signed)
	7. North Oaks ImPACT Consent for Baseline Cognitive Testing & Release of Information Form
	8. A \$30 insurance payment will be due upon making any team (this is a one time payment)
	9. Do you currently live in Hammond High Magnet School Attendance Zone? YES or NO (circle one)

*No student will be allowed to try out or participate for any team without this paperwork on file. ALL forms must be completed, signed and submitted prior to tryouts.*

# 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"/>	High Blood Pressure	_____	<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,

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. .... **Yes** **No**
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. .... **Yes** **No**
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. .... **Yes** **No**
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) ..... **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
<b>I. Spine / Neck</b>		
Cervical	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>
<b>II. Upper Extremity</b>		
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>
Wrist	<input type="checkbox"/>	<input type="checkbox"/>
Hand / Fingers		
<b>III. Lower Extremity</b>		
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 13 months from the date it was signed and dated by the MD, DO, APRN or PA.

# Louisiana High School Athletic Association

## Athletic Participation/Parental Permission Form

*This form must be completed and signed **by the student-athlete's parent** prior to a student's participation in an athletic contest and shall be kept on file with the school. **It shall remain in effect for the remainder of the student's eligibility unless the student transfers to another member school.** This form is subject to **review/inspection** by the LHSAA **or its representative.***

### **PART I: STUDENT INFORMATION** (Please Print)

Student's Name: (Last, First, Middle) \_\_\_\_\_ School Year: 2022-2023

Date of Birth: \_\_\_\_\_ Last Four Digits of SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

My child entered ninth grade in \_\_\_\_\_ (month and year). Last semester/year he/she attended \_\_\_\_\_ High School.

### **ARE YOU ELIGIBLE?**

A student athlete in an LHSAA school must meet the following rules to be eligible for interscholastic athletic competition:

<b><u>RULE</u></b>	<b><u>COMMENTS</u></b>
<b>BONA FIDE STUDENT</b>	A student shall be enrolled in and attending an LHSAA member school on a regular basis and taking the required number of subjects which shall be recorded on the student's official transcript unless student is a special education student or in the 8 <sup>th</sup> grade or below. A student shall must be counted as a student on the daily attendance records of the school he/she attends. Attendance in one class makes you a student at that school.
<b>ENROLLMENT</b>	A student shall be enrolled and attending a school in the first 11 school days of the school semester at any school or will be ineligible for the first 30 school days.
<b>AGE</b>	A student shall not become 19 years of age prior to August 1 of this year.
<b>PROOF OF AGE</b>	A student shall provide legal proof of age, which meets the provisions of the LHSAA handbook, to the school administrator to be kept on file at school.
<b>CONSECUTIVE SEMESTERS</b>	Once a student shall enter the ninth grade, he/she shall have eight consecutive semesters to play athletics. (EXCEPTION: Hold-Back Repeat Student – See Rule 1.20.6 of the LHSAA handbook)
<b>SCHOLASTIC</b>	<p>For regular education high school students at the end of the first semester a student shall <b>pass at least six subjects</b> in all subjects taken.</p> <p>At the end of the year and prior to the next school year, a student shall must have <b>earned at least six units with an overall "C" average for the entire previous school year</b> as determined by the LEA in all units taken. 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>
<b>RESIDENCE AND SCHOOL TRANSFERS</b>	Upon entering high school for the first time, a student shall have the choice to attend any member school located in the attendance zone 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 attendance zone shall render the student ineligible for one calendar year.
<b>UNDUE INFLUENCE</b>	If a student shall has been recruited to a school for athletic purposes, he/she shall remain ineligible as long as the student attends that school.
<b>AMATEUR</b>	A student cannot play high school athletics if he/she loses their amateur status.
<b>INDEPENDENT TEAM</b>	In certain sports a student cannot play on a school team and an independent team during the same sport season.

**MEDICAL EXAMINATION**

A student shall **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 **only** be required to have this form completed and signed prior to **the first time** **a student participates** in LHSAA athletics at the school **unless the student transfers to another member 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**

Shall not 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 a student earns by meeting standards outlined on this form and other regulations and policies set by the LHSAA and the student's school. If you have questions or do not fully understand an eligibility rule, check with your child's principal, athletic director or coach. By following the intent and spirit of the rules, you can help prevent violations which may penalize the student, his/her team and/or his/her school.

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

**PART II – PARENTAL PERMISSION**

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

I certify the home address listed **on this form** is my sole bona fide residence and **that I** will notify the school principal immediately of any change in **my** residence, since such a move may alter the eligibility status of my child. All other information given 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 its representative(s) permission to review my child's scholastic records and all required eligibility forms **however submitted by the school or myself.**

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 **my child** 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

I certify all the information is correct, that I have read the summary of LHSAA eligibility rules below and I am in compliance with these standards. I also acknowledge that my child, by my signature below, has my permission to participate in interscholastic athletics during his attendance at this school. I also understand that this form shall only be completed prior to my child's first participation in any athletic contest of any sport and shall remain in effect for his/her entire athletic eligibility unless he/she transfers to another member school.

**By signing below, I agree that my child and I will support and comply with all rules, policies and procedures of the LHSAA as set forth in its Handbook, including its Constitution and Bylaws.**

Date: \_\_\_\_\_ Parent's Signature: \_\_\_\_\_

Relationship to Student \_\_\_\_\_ (Print Name) \_\_\_\_\_

(Principal Signature) Shelly C. Gaydos



## 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

Dated: 4/01/2022

Shelly C. Gaydos

Dated: 4/01/2022

Amber A. Babin

\_\_\_\_\_  
Head Coach or AD

**1.9 ABUSE AND/OR MISUSE OF ILLEGAL SUBSTANCES** - Each member school shall develop and implement a substance abuse/misuse policy including procedures for chemical testing of student-athletes. To be eligible for interscholastic athletics, prior to practicing or participating in a sport at an LHSAA school, a student-athlete and his/her parent(s)/guardian shall sign the LHSAA Substance Abuse/Misuse Contract developed and distributed to all schools by the LHSAA. Once signed, the LHSAA Substance Abuse/Misuse Contract shall remain in effect for the remainder of the student-athlete's eligibility. Schools may also have the student and parent/guardian sign a school issued form in addition to the LHSAA Substance Abuse/Misuse Contract. Schools shall be required to keep the signed form on file at the school.

**1.9.1** The penalties for failure to have the required LHSAA Substance Abuse/Misuse Contract(s) for all students completed, properly signed, and maintained in the school files shall be:

1. A school shall be fined \$50 per student, per sport for each LHSAA Substance Abuse/Misuse Form not completed, properly signed, and on file with the school not to exceed \$500 per sport.

2. A student in violation of this rule shall not be ruled ineligible for this infraction, but shall be withheld from further team practices and interscholastic athletic participation until a copy of this form is completed and submitted to the Executive Director. The completed form must be faxed or postmarked prior to the athlete's participation

**Signature of the LHSAA's contract does not necessarily mean the student athlete will be tested.**



P. O. Box 2668 HAMMOND, LA 70404  
(985) 345-2700

### AUTHORIZATION TO DISCLOSE DRUG SCREEN RESULTS

I hereby authorize **NORTH OAKS HEALTH SYSTEM** to disclose the drug screen results of:

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Release to:**

**Client Name:** Tangipahoa Parish School System **School:** \_\_\_\_\_

**Sport:** \_\_\_\_\_

The information will be disclosed for the following purpose:

**Student athlete random drug screen required for participation in school athletics.**

#### **FOR RELEASE OF INFORMATION TO SOMEONE OTHER THAN TO THE PATIENT:**

Health information released as a result of this authorization may be re-disclosed or shared by the person or entity receiving the information and may not be protected by federal/state regulations.

I understand that I may refuse to sign this authorization. I further understand that my refusal to sign will not affect my ability to obtain treatment unless a third party requests the service and/or release of information. (For example, if you present for a drug test solely for the purpose of having the results disclosed to your employer, North Oaks may refuse to perform the drug test if you refuse to sign this form.)

I understand that I may revoke this authorization in writing at any time. Revocation will be effective when received by North Oaks Health System. I further understand that any information already authorized and released is not covered by this revocation.

Drug screen results are utilized for athletic eligibility purposes. This authorization expires upon completion of athletic eligibility.

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Parent/Legal Guardian**

\_\_\_\_\_  
**Donor/Student's Signature**

**Not of Legal Age**

\_\_\_\_\_  
**Reason Donor/Student Cannot Sign**

(A copy of this signed form will be provided to the donor/student as the drug screen collection is performed)

**Louisiana High School Athletic Association**  
**Parent and Student-Athlete Concussion Statement**

☐ I understand that it is my responsibility to report all injuries and illnesses to my coach, athletic trainer and/or team physician.

☐ I have read and understand the Concussion Fact Sheet.

After reading the Concussion Fact Sheet, I am aware of the following information:

Parent Initial	Student Initial	
_____	_____	A concussion is a brain injury, which I am responsible for reporting to my coach , athletic trainer, or team physician.
_____	_____	A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance
_____	_____	You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.
_____	_____	If I suspect a teammate has a concussion, I am responsible for reporting the injury to my coach, athletic trainer, or team physician.
_____	_____	I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.
_____	_____	Following concussion the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.
_____	_____	In rare cases, repeat concussions can cause permanent brain damage, and even death.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Student-Athlete

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Parent/Guardian







P.O. Box 2668 • HAMMOND, LA 70404 • (985) 345-2700

## AUTHORIZATION

I hereby authorize North Oaks Health System to photograph my image, interview and/or record my testimony for the purpose of promotion of North Oaks Health System and/or its wholly-owned subsidiaries and other affiliated entities (hereinafter "NOHS"). Examples of promotion include, but are not limited to, brochures, newsletters, TV and radio commercials, newspaper ads, NOHS web-sites (i.e., [www.northoaks.org](http://www.northoaks.org)), and social media networks (i.e., YouTube, Facebook, Twitter). I understand that I may refuse to sign this authorization. I further understand that my refusal to sign will not affect my ability to obtain treatment.

I understand that I may revoke this authorization in writing at any time sent to the attention of NOHS Corporate Communications, P.O. Box 2668, Hammond, LA 70404. I understand that I will not be financially compensated for the use of my image.

Revocation will be effective when received by NOHS. I further understand that any information already authorized and released/used is not covered by this revocation. NOHS will not receive monetary benefit from the use/disclosure of this information.

This authorization expires five (5) years from the date of signature below.

Print Name: \_\_\_\_\_  
(Subject of photograph or interview)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Subject's School Name: \_\_\_\_\_

Subject's Sport(s): \_\_\_\_\_

Subject's Jersey Number(s): \_\_\_\_\_

\_\_\_\_\_  
Signature of Interviewee (Parent/Guardian, if Minor)                      Date

(A copy of this signed authorization must be provided to the individual.)

FOR OFFICE USE ONLY.

Related Project: \_\_\_\_\_



Dear Parent/Guardian,

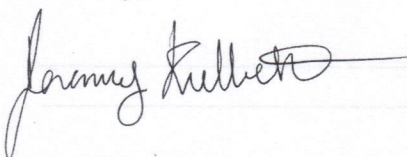
North Oaks Sports Medicine is using Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT®), an advanced program to help our team physicians and athletic trainers evaluate and treat traumatic brain injuries (e.g., concussion) in our student-athletes. ImPACT® is a computerized exam used by many professional, college and high school sports programs across the country. If an athlete is believed to have suffered a head injury during practice or competition, ImPACT® is a tool that can be used by a trained health care professional to evaluate the seriousness of the head injury and the athlete's recovery from that injury. Your permission is required before we can test your student-athlete.

Ideally, the computerized exam is given to athletes before beginning contact sport practice or competition. This simple test is set up in a video-game type format and takes about 20 minutes to complete. It tracks information such as memory, reaction time, speed and concentration. In addition, to help health care providers better understand the athlete's particular health care situation, there are also questions about the athlete's health history as well as current symptoms that he or she may be experiencing. ImPACT® is not an IQ test and is non-invasive (no surgical cuts or breaks to the skin are required).

If a concussion is suspected, the athlete will be required to retake the test. The athlete's performance on the post-injury test will be compared to his or her performance on the baseline and any differences in performance will be evaluated by a trained health care provider. The test data will help trained health care professionals determine when return-to-activity is appropriate and safe for the injured child.

I wish to stress that the ImPACT® testing procedures pose no known risks to your student-athlete. We are excited to implement this program because it provides us the best available information for managing concussions. Please return the attached page with the appropriate signatures by \_\_\_\_\_. If you have further questions regarding this program please feel free to email me at kulbethj@northoaks.org or call me at (985) 230-5248.

Sincerely,



Jeremy Kulbeth  
Lead High School Athletic Trainer  
North Oaks Sports Medicine



# CONSENT FOR BASELINE COGNITIVE TESTING AND RELEASE OF INFORMATION

## NOTE OF CONSENT

I give my permission for (Student-Athlete's Full Name) \_\_\_\_\_  
to have a baseline Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT®) test administered at  
(Facility Location) \_\_\_\_\_. I understand that my child may need to be tested more than  
once, depending upon the results of the test. I understand there is no charge for the testing.

Student-Athlete's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Student-Athlete's Mailing Address: \_\_\_\_\_

Full Name of Parent/Guardian (Please print): \_\_\_\_\_

Parent/Guardian Phone Number: (\_\_\_\_) \_\_\_\_\_ Preferred Time to Call: \_\_\_\_\_ (a.m. or p.m.)

Signature of Parent/Guardian: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## RELEASE OF INFORMATION

North Oaks Sports Medicine may release the ImPACT® test results to my child's primary care  
physician, neurologist, other treating physician or any licensed health care professional listed below:

Physician/Licensed Health Care Professional (First and Last Name): \_\_\_\_\_

Clinic or Practice Name: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Physician/Licensed Health Care Professional (First and Last Name): \_\_\_\_\_

Clinic or Practice Name: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Physician/Licensed Health Care Professional (First and Last Name): \_\_\_\_\_

Clinic or Practice Name: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

I understand that general information about the test data may be provided to my child's guidance  
counselor and teachers for the purposes of providing temporary academic modifications, if necessary.

Signature of Parent/Guardian: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_