



# Archbishop Hannan High School

## CO-CURRICULAR STUDENT ACTIVITY PACKET

### ATTENTION PARENTS:

To avoid delaying your child's ability to participate in practice or games,  
it is very important that all forms are filled out and signed by parent and student.

Please note that a physical will NOT be accepted without the LHSAA physical packet filled out completely, including the yes or no questions and parent signature on the physical.

To keep in compliance with the LHSAA a new physical and packet must be completed each year. First time athletes must include a copy of birth certificate.

### Check List:

\_\_\_\_ LHSAA Medical History Evaluation

\_\_\_\_ LHSAA Athletic Participation/Parental Permission

\_\_\_\_ LHSAA Substance Abuse/Misuse Contract and Consent

\_\_\_\_ LHSAA Parent and Student-Athlete Concussion Statement

\_\_\_\_ Birth Certificate (first time athlete only)

\_\_\_\_ Emergency Contact Information

\_\_\_\_ Permission to Dispense OTC medication

# 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 Mononucleosis                        |
| <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 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: \_\_\_\_\_

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 1.26.6 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) \_\_\_\_\_



## 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: \_\_\_\_\_

\_\_\_\_\_  
Principal

Dated: \_\_\_\_\_

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

**1.10 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.

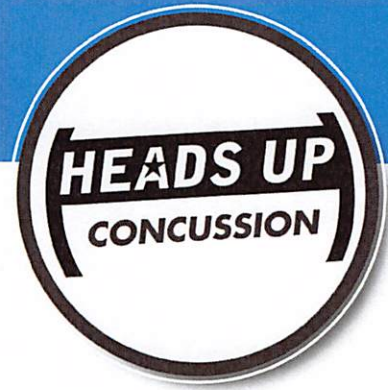
**1.10.1** The penalties for failure to have the required LHSAA Substance Abuse/Misuse Contract(s) for all students completed, properly signed, and maintained in the school files shall be:

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.**



# PARENT & ATHLETE CONCUSSION INFORMATION SHEET



## WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

## WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

### DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

## SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

## SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

[ INSERT YOUR LOGO ]



**"IT'S BETTER TO MISS ONE GAME  
THAN THE WHOLE SEASON"**

## CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

## WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.
2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.
3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

## WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

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STUDENT-ATHLETE NAME PRINTED

---

STUDENT-ATHLETE NAME SIGNED

---

DATE

---

PARENT OR GUARDIAN NAME PRINTED

---

PARENT OR GUARDIAN NAME SIGNED

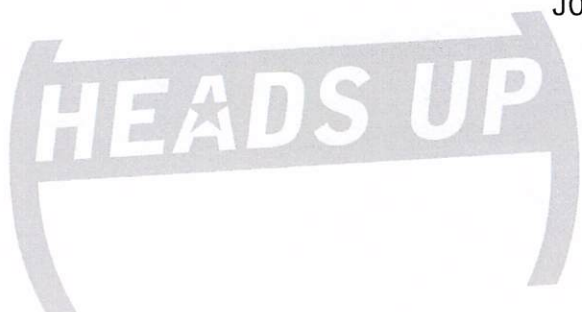
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DATE

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TO LEARN MORE GO TO >> [WWW.CDC.GOV/CONCUSSION](http://WWW.CDC.GOV/CONCUSSION)

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).



# STUDENT-ATHLETE INFORMATION

(Please write legibly using blue or black ink)

Athlete - Last Name: \_\_\_\_\_ Athlete - First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YY) ☐ Male ☐ Female

Sport(s): \_\_\_\_\_ ☐ 8<sup>th</sup> Grade ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior

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

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

Student-Athlete - Cell Phone: \_\_\_\_\_

Student-Athlete - Email Address: \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

Parent/Guardian - Name: \_\_\_\_\_ Parent/Guardian - Cell Phone: \_\_\_\_\_

Parent/Guardian - Name: \_\_\_\_\_ Parent/Guardian - Cell Phone: \_\_\_\_\_

Parent/Guardian - Email Address: \_\_\_\_\_

Parent/Guardian - Email Address: \_\_\_\_\_

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## EMERGENCY CONTACTS

(Please list one contact other than parent/guardian)

Primary Contact: \_\_\_\_\_ Relationship to Student-Athlete: \_\_\_\_\_

\_\_\_\_\_  
Cell Phone #

\_\_\_\_\_  
Alternate Phone #

*In an emergency, I authorize the Archbishop Hannan Department of Sports Medicine and affiliated providers to contact the person(s) listed above.*

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

Date \_\_\_\_\_

Parent/Guardian - Signature: \_\_\_\_\_

Date \_\_\_\_\_



**Permit to Administer/ Dispense Over the Counter (OTC) Medication**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

**OTC (Over The Counter) Medications:**

Please read and sign the following for the administration of medications to your child, or initial the Administer no Medication statement.

Administer NO Medication: \_\_\_\_\_

I, \_\_\_\_\_, by below signature, hereby hold the Certified Athletic Trainer, Archbishop Hannan High School, and Ochsner Health harmless in the administration of pre-packages, non-prescription (OTC) medications to the above listed student. I understand that the certified athletic trainer will provide the medication in single dose only. Ochsner Health, Archbishop Hannan High School, and the Certified Athletic Trainer accept no responsibility for OTC medications that are defective, either by their design or dosage recommendations or that are misused by the athlete. The misuse of medications will result in the athlete's loss of medication privileges.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**I hereby grant permission for the certified athletic trainer to administer the following OTC medications:**

Only initial those that you desire administered

\* Listed are brand names and their active ingredients- please note, actual medications may be of a generic name.

\_\_\_\_\_ Advil (Ibuprofen)

\_\_\_\_\_ Aleve (Naproxen Sodium)

\_\_\_\_\_ Pepto-Bismol (Bismuth subsalicylate)

\_\_\_\_\_ Tylenol (Acetaminophen)

\_\_\_\_\_ Benadryl (Diphenhydramine HCl/Antihistamine)

\_\_\_\_\_ Electrolytes Gatorlytes, Medi-Lyte (Calcium Carbonate, Potassium Chloride, Magnesium Oxide) \*All these are for dehydration and muscle cramping due to participating in sport\*

**This authorization shall remain effective until the end of the current academic school year.**

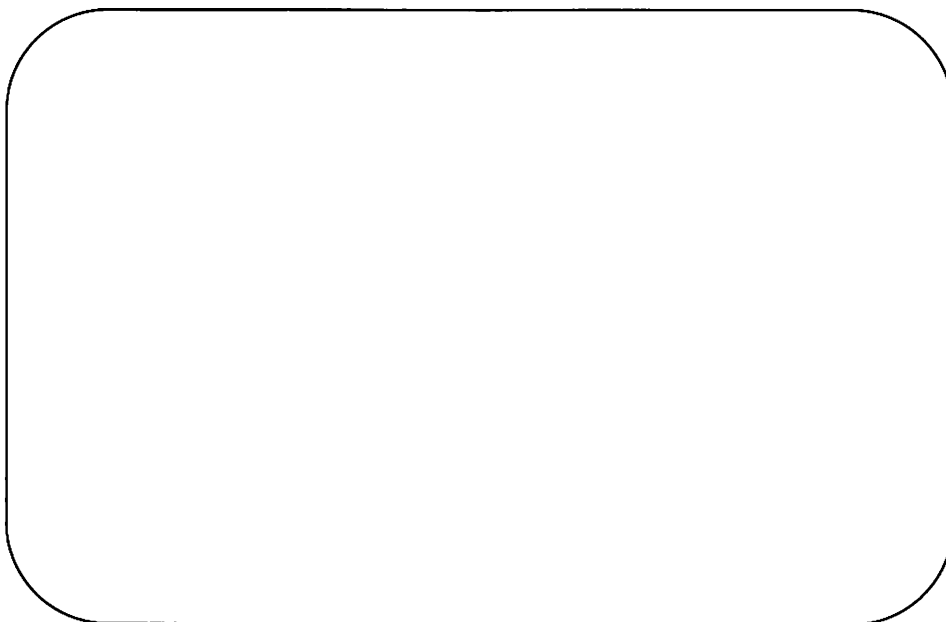
# INSURANCE CARD

## Health Insurance

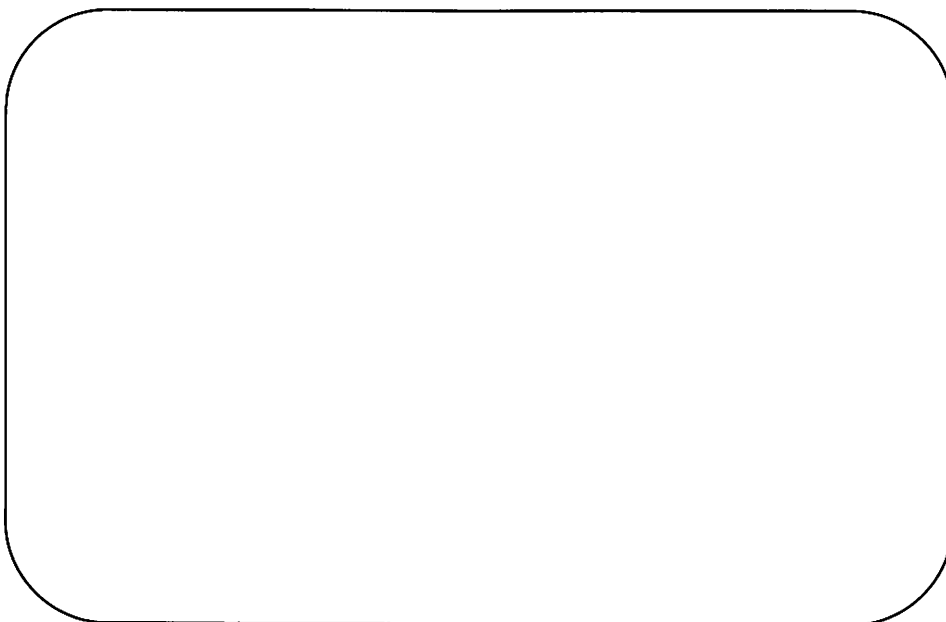
*(Please provide one front and back copy of your health insurance card)*

Athlete - Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sport: \_\_\_\_\_

Copy **FRONT** of insurance card below



Copy **BACK** of insurance card below



**\*\*Should you choose not to use this exact page to provide a copy of your insurance card, please follow the above format including the student-athlete's name, date of birth and sport at the top of the page\*\***