

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	Yes	No	Condition	Whom	Yes	No	Condition	Whom
☐	☐	Heart Attack/Disease	_____	☐	☐	Sudden Death	_____	☐	☐	Arthritis	_____
☐	☐	Stroke	_____	☐	☐	High Blood Pressure	_____	☐	☐	Kidney Disease	_____
☐	☐	Diabetes	_____	☐	☐	Sickle Cell Trait/Anemia	_____	☐	☐	Epilepsy	_____

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

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

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

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

Date Signed by Parent _____

Signature of Parent _____

Typed or Printed Name of Parent _____

Health Care Provider section on page 2

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

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 _____
--------------	--------------	----------------------	-------------

GENERAL MEDICAL EXAM :

	Norm	Abnl
ENT	☐	☐
Lungs	☐	☐
Heart	☐	☐
Abdomen	☐	☐
Skin	☐	☐

ORTHOPAEDIC EXAM :

I. Spine / Neck

	Norm	Abnl
Cervical	☐	☐
Thoracic	☐	☐
Lumbar	☐	☐

II. Upper Extremity

	Norm	Abnl
Shoulder	☐	☐
Elbow	☐	☐
Hand / Fingers	☐	☐
Wrist	☐	☐

III. Lower Extremity

	Norm	Abn
Knee	☐	☐
Hip	☐	☐
Ankle	☐	☐

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 _____

Revised 5/23

This physical expires 13 months from the date it was signed and dated by the MD, DO, APRN or PA.

Please fill out front + back + return to front office.

School Waiver Form
Extracurricular Activities

The St. Tammany Parish School Board, its employees, agents and insurers have no liability, and accept no liability for injuries or accidents occurring to students during their participation in interscholastic athletics or sports and related extracurricular teams or activities. The student and parent(s)/guardian(s) assume any and all risks, including without limitation risk of injury and risk of incurring medical expenses associated with the participation by the student.

****Complete every item below****

Student's Name: _____ **Sport:** _____

Sex: M F **School:** _____ **Grade:** _____

Age: _____ **Date of Birth:** ____/____/____

Parent's/Guardian's Name: _____

Home Address: _____ **Home Phone Number:** _____

Work Phone Number: _____ **Cell Phone Number:** _____

2nd Person to Contact: _____ **Relationship to student:** _____

2nd Contact Phone Number: _____

Insurance Company: _____

Policy Number and/or Group Numbers: _____

ALLERGIES: _____

Parent's/Guardian's signature: _____

Date: _____

IMPORTANT - It is the policy of St. Tammany Parish School Board that ALL athletes participating in our school sports programs **MUST HAVE EITHER MEDICAL OR ACCIDENT INSURANCE IN ORDER TO PARTICIPATE**. Please be sure to provide that information on this form. This information also becomes important in case of injury or illness and we are unable to immediately contact parent/guardian.

Please fill out front + back + return to front office.

**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

