LHSAA MEDICAL HISTORY EVALUATION

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. 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) or the associated medical personnel. ..... 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	☐	☐
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	Abnl
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.**

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,

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) 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.**

EVALUACIÓN DEL HISTORIAL MÉDICO DE LOUISIANA HIGH SCHOOL ATHLETIC ASSOCIATION (LHSAA)

IMPORTANTE: El presente formulario debe completarse *anualmente*, mantenerse archivado en la escuela y está sujeto a inspección por parte del Equipo de Cumplimiento de Reglas.

Imprimir

Nombre:_____ Escuela:_____ Grado:_____ Fecha:_____

Deporte(s):_____ Sexo: M/F Fecha de nacimiento:_____ Edad:_____ Teléfono celular:_____

Domicilio:_____ Ciudad:_____ Estado:_____ Código postal:_____ Teléfono residencial:_____

Padre/Tutor:_____ Empleador:_____ Teléfono del trabajo:_____

ANTECEDENTES MÉDICOS FAMILIARES: ¿Algún miembro de su familia menor de 50 años ha tenido estas condiciones?

Sí	No	Condición	Quién	Sí	No	Condición	Quién	Sí	No	Condición	Quién
☐	☐	Ataque/enfermedad cardíaca	_____	☐	☐	Muerte súbita	_____	☐	☐	Artritis	_____
☐	☐	Ataque cerebral	_____	☐	☐	Presión arterial alta	_____	☐	☐	Nefropatía	_____
☐	☐	Diabetes	_____	☐	☐	Rasgo de células falciformes/Anemia	_____	☐	☐	Epilepsia	_____

ANTECEDENTES ORTOPÉDICOS DEL ATLETA: ¿El atleta ha tenido alguna de las siguientes lesiones?

Sí	No	Condición	Fecha	Sí	No	Condición	Fecha	Sí	No	Condición	Fecha
☐	☐	Lesión en la cabeza / Concusión	_____	☐	☐	Lesión/dolor punzante en el cuello	_____	☐	☐	Hombro I / D	_____
☐	☐	Codo I / D	_____	☐	☐	Brazo/Muñeca/Mano I / D	_____	☐	☐	Espalda	_____
☐	☐	Cadera I / D	_____	☐	☐	Muslo I / D	_____	☐	☐	Rodilla I / D	_____
☐	☐	Parte inferior de la pierna I / D	_____	☐	☐	Periostitis tibial	_____	☐	☐	Tobillo I / D	_____
☐	☐	Pie I / D	_____	☐	☐	Distensión muscular severa	_____	☐	☐	Nervio pinzado	_____
☐	☐	Pecho	_____			Antecedentes de cirugías:	_____				

ANTECEDENTES MÉDICOS DEL ATLETA: ¿El atleta ha tenido alguna de estas condiciones?

Sí	No	Condición	Sí	No	Condición	Sí	No	Condición
☐	☐	Soplo cardíaco / dolor en el pecho / opresión	☐	☐	Asma / Inhalador recetado	☐	☐	Irregularidades menstruales: último ciclo:_____
☐	☐	Convulsiones	☐	☐	Dificultad para respirar / Tos	☐	☐	Pérdida/aumento rápido de peso
☐	☐	Nefropatía	☐	☐	Hernia	☐	☐	Toma suplementos/vitaminas
☐	☐	Arritmia	☐	☐	Noqueado / Concusión	☐	☐	Problemas relacionados con el calor
☐	☐	Testículo único	☐	☐	Enfermedad cardíaca	☐	☐	Mononucleosis reciente
☐	☐	Presión arterial alta	☐	☐	Diabetes	☐	☐	Bazo agrandado
☐	☐	Mareo/Desmayos	☐	☐	Enfermedad hepática	☐	☐	Rasgo de células falciformes/anemia
☐	☐	Pérdida de órganos (riñón, bazo, etc.)	☐	☐	Tuberculosis	☐	☐	Debió pasar una noche en el hospital
☐	☐	Cirugía	☐	☐	Prescripción de inyección de Epinefrina (EPI PEN)	☐	☐	Alergias (alimentos, medicamentos)_____

☐ ☐ Medicamentos _____

Lista de fechas para: Última vacuna contra el tétanos_____: Inmunización contra el sarampión_____: Vacuna contra la meningitis: _____

FORMULARIO PARA PADRES DE RENUNCIA A RECLAMACIONES

A nuestro leal saber y entender, hemos dado información verdadera y precisa y por la presente autorizamos la evaluación de revisión física. Entendemos que la evaluación implica un examen limitado y que no tiene como propósito ni podrá prevenir lesiones o muerte súbita. Además, entendemos que si el examen se proporciona sin expectativa de pago, de conformidad con el título 9:2798 de los Estatutos Revisados de Luisiana no habrá causa de acción contra el profesional de la salud voluntario del equipo y/o empleador de acuerdo a la ley de Luisiana.

La presente renuncia a reclamaciones, otorgada en la fecha a continuación por el abajo firmante, médico, médico osteópata, enfermero facultativo o asistente médico y padre del estudiante atleta mencionado anteriormente, se realiza de conformidad con la ley de Luisiana con el pleno entendimiento de que no habrá causa de acción por ninguna pérdida o daño causado por cualquier acto u omisión relacionada con los servicios de atención médica si en lo sucesivo se prestan de forma voluntaria y sin expectativa de pago, a menos que tal pérdida o daño fueran causados por negligencia grave. Adicionalmente,

1. Si, a juicio de un representante de la escuela, el estudiante-atleta mencionado necesita atención o tratamiento como resultado de una lesión o enfermedad, por la presente solicito, doy mi consentimiento para y autorizo los cuidados que se consideren necesarios..... **Sí No**
2. Entiendo que si el estado médico de mi hijo/a cambia de manera significativa después de su examen físico, notificaré inmediatamente a su director acerca del cambio..... **Sí No**
3. Doy mi permiso para que el entrenador deportivo comparta la información de las lesiones de mi hijo/a al entrenador en jefe / director deportivo / director de su escuela..... **Sí No**
4. Con mi firma a continuación, acepto permitir que se revisen los antecedentes médicos / formulario de examen de mi hijo/a y todos los formularios de elegibilidad por la LHSAA o su(s) representante(s) o el personal médico asociado. ..... **Sí No**

_____ **Fecha de firma del padre o madre**

_____ **Firma del padre o madre**

_____ **Nombre en letra de molde o escrito a máquina**

Sección del profesional de la salud en la página 2

EVALUACIÓN DEL HISTORIAL MÉDICO DE LHSAA

IMPORTANTE: Este formulario debe completarse *anualmente*, mantenerse archivado en la escuela y está sujeto a inspección por parte del Equipo de Cumplimiento de Reglas.

Nombre:_____ Fecha de nacimiento:_____ Edad:_____

Fecha:_____

Escuela:_____ Grado:_____Deporte(s):_____

II. PARA QUE COMPLETE ANUALMENTE EL MÉDICO (MD), MÉDICO OSTEÓPATA (DO), ENFERMERO (APRN) o AUXILIAR MÉDICO

Altura _____	Peso _____	Presión sanguínea_____	Pulso_____

EXAMEN MÉDICO GENERAL:

	Normal	Anormal
Otorrino	☐	☐
Pulmones	☐	☐
Corazón	☐	☐
Abdomen	☐	☐
Piel	☐	☐

EXAMEN ORTOPÉDICO :

I. Columna vertebral / cuello

	Normal	Anormal
Cervical	☐	☐
Torácico	☐	☐
Lumbar	☐	☐

II. Extremidad superior

	Normal	Anormal
Hombro	☐	☐
Codo	☐	☐
Mano / Dedos	☐	☐
Muñeca	☐	☐

III. Extremidad inferior

	Normal	Anormal
Rodilla	☐	☐
Cadera	☐	☐
Tobillo	☐	☐

Notas del profesional de la salud (si fuera necesario):_____

[ ] Médicamente apto para todos los deportes sin restricciones

[ ] Médicamente apto para algunos deportes_____

[ ] Médicamente apto para todos los deportes sin restricciones bajo recomendación de evaluación o tratamiento adicionales para_____

[ ] Médicamente no apto, pendiente de evaluación adicional

[ ] Médicamente no apto para ningún deporte

Esta recomendación se basa en una evaluación limitada.

_____	_____	_____
Nombre en letra de molde del médico, médico osteópata, enfermero o auxiliar médico	**Firma del médico, médico osteópata, enfermero o auxiliar médico**	**Fecha del examen médico**

Este formulario de aptitud física vence a los 13 meses de la fecha en que fue firmado y fechado por el médico, médico osteópata, enfermero o auxiliar médico.

Revisado 5/23