Below is the updated physical schedule.

| **Ochsner Elmwood**<br>1201 S. Clearview Pkwy Bld. B<br>Jefferson, LA 70121 | | **Truman Middle School**<br>5417 Ehret Rd<br>Marrero, LA 70072 | |
|---|---|---|---|
| **Time** | **School** | **Time** | **School** |
| 8:00 AM | Haynes / Riverdale | 8:00 AM | Livaudais / Boudreaux / Woodland West |
| 8:15 AM | EJ | 8:15 AM | TJ |
| 8:30 AM | Patrick Taylor | 8:30 AM | Patrick Taylor / West Jeff |
| 8:45 AM | Adams / Bissonet / Chateau | 8:45 AM | Higgins / Ehret |
| 9:00 AM | Jefferson / Hazel Park / Harahan / Moscona | 9:00 AM | Fisher / Gilbert / Cherbonnier |
| 9:15 AM | Benson / Alexander / Audubon / Woods | 9:15 AM | Ellender / CT Janet / Estelle |
| 9:30 AM | Miesler / JC Ellis / Bricolage | 9:30 AM | Marrero / Lincoln |
| 9:45 AM | Bonnabel / TH Harris / Rudolf Matas | 9:45 AM | Truman / Woodmere |
| 10:00 AM | Kenner Discovery | 10:00 AM | AOL |
| 10:30 AM | The Willow School | | |

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AUGUST 02, 2024 | 12:01 AM

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Jefferson Parish Public School System has partnered with Ochsner Sports Medicine Institute (OSMI) to provide medical care, through the use of their Athletic Training Outreach Program, to keep student athletes healthy and on the field during the athletic season.

OSMI is home to the largest Athletic Training Outreach Program in the state of Louisiana. Each Athletic Trainer in Ochsner's outreach program is licensed by the Louisiana State Board of Medical Examiners and has earned a degree from an accredited athletic training curriculum. Accredited programs include formal instruction in areas such as injury/illness prevention, first aid and emergency care, assessment of injury/illness, human anatomy and physiology, therapeutic modalities, and nutrition. Ochsner's Athletic Trainers stay innovative and maintain certification requirements through local and national continuing medical education meetings and conferences.

## What is athletic training?

Athletic training encompasses the prevention, examination, diagnosis, treatment and rehabilitation of emergent, acute or chronic injuries and medical conditions. Athletic training is recognized by the American Medical Association (AMA), Health Resources Services Administration (HRSA) and the Department of Health and Human Services (HHS) as an allied health care profession. http://www.nata.org/about/athletic-training

## Who are Athletic Trainers?

Athletic Trainers (ATs) are highly qualified, multi-skilled health care professionals who collaborate with physicians to provide preventative services, emergency care, clinical diagnosis, therapeutic intervention and rehabilitation of injuries and medical conditions. Athletic Trainers work under the general supervision of a physician, as well as, execute prescribed treatments.

Athletic Trainers are sometimes confused with personal trainers. There is, however, a large difference in the education, skillset, job duties and patients of an Athletic Trainer and a personal trainer. The athletic training academic curriculum and clinical training follows the medical model. http://www.nata.org/about/athletic-training

The partnership between Jefferson Parish Public School System and OSMI does not obligate the student athlete and their family to use their services.

**Ochsner Health Sports Medicine Institute**
1201 S. Clearview Parkway
Building B, Suite 104
Jefferson, LA 70121
504-736-4800
https://www.ochsner.org/services/sports-medicine-institute

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 |
|---|---|---|---|
| ☐ | ☐ | Ataque/enfermedad cardíaca | _____ |
| ☐ | ☐ | Ataque cerebral | _____ |
| ☐ | ☐ | Diabetes | _____ |
| ☐ | ☐ | Muerte súbita | _____ |
| ☐ | ☐ | Presión arterial alta | _____ |
| ☐ | ☐ | Rasgo de células falciformes/Anemia | _____ |
| ☐ | ☐ | Artritis | _____ |
| ☐ | ☐ | Nefropatía | _____ |
| ☐ | ☐ | Epilepsia | _____ |

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

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

Antecedentes de cirugías: _____

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

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

# 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:

| RULE | COMMENTS |
|---|---|
| **BONA FIDE STUDENT** | 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 8th 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. |
| **ENROLLMENT** | 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. |
| **AGE** | A student shall not become 19 years of age prior to August 1 of this year. |
| **PROOF OF AGE** | 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. |
| **CONSECUTIVE SEMESTERS** | 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) |
| **SCHOLASTIC** | For regular education high school students at the end of the first semester a student shall **pass at least six subjects** in all subjects taken.<br><br>At the end of the year and prior to the next school year, a student shall must have **earned at least six units with an overall "C" average for the entire previous school year** as determined by the LEA in all units taken. All seniors must take at least four (4) subjects each semester.<br><br>Special education students must consult the school principal, athletic director, or coach for scholastic information. |
| **RESIDENCE AND SCHOOL TRANSFERS** | 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. |
| **UNDUE INFLUENCE** | 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. |
| **AMATEUR** | A student cannot play high school athletics if he/she loses their amateur status. |
| **INDEPENDENT TEAM** | 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 ELIGIBLITY 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 it 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.**

## 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

LHSAA

# CONCUSSION MANAGEMENT PROGRAM
# STUDENT PARTICIPATION APPLICATION

My child, _____ (Name of Student), has my permission to participate in the Concussion Management Program at _____(School Name). We have studied the requirements for participation and agree to its terms. We understand that the collected data from the ImPACT testing on my child will be confidential and can be reviewed only by the athletic trainer of my child's school and a physician. the viewing of my child's records by any other person must have expressed permission in writing. questions can be answered by contacting the coach, principal or athletic trainer of the sport/school.

☐ Yes, I approve participation ☐ No, I do not want my child to participate

_____ _____
Student's Signature Date

_____ _____
Parent or Legal Guardian's Signature Date

_____
Print Parent or Legal Guardian's Name

Please complete all of the information requested below:

Name of Student: _____

Address: _____

Home Phone: _____ Age: _____ Grade: _____

Mother's Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Father's Name: _____

Address: _____

# CONCUSSION MANAGEMENT PROGRAM
# FACT SHEET

The Concussion Management Program is created for the protection of the students in participation in senior high school athletics, dance, cheerleading, and select clubs such as lacrosse and equestrian henceforth for this program collectively known as "student athletes" - while performing their activities in which physical contact is a component of the sport. this program will provide strong framework by which safety of practicing and potential for head injury and subsequent concussion may be gauged.

The use of computerized neurocongnitive testing to evaluate the concussed athlete with persistent symptoms affecting short-term memory, reaction time, problem solving, etc. has been found to be an extremely helpful tool allowing for more safe, expedient return of the student athlete to sports, decreasing the risk of prolonged concussion-related symptoms and development of post-concussion syndrome. As a proactive measure, the program began in 2010-2011 in Northshore schools and 2011-2012 in Jefferson Parish. All student athletes are strongly encouraged to participate in the Concussion Management Program. It is in conjunction with Ochsner Pediatric & Adolescent Concussion Management Program which utilizes the ImPACT neurocongnitive test (www.impacttest.com). All the test results will be confidential and can only be reviewed by the assigned athletic trainer or a physician.

Enrollment in the program *does not* require a student athlete to seek medical treatment from an Ochsner healthcare provider or at an Ochsner facility for an injury sustained while participating in a school sponsored athletic event. A student athlete may seek medical treatment from his/her traditional healthcare provider or as insurance requires for any injury sustained while participating in a school sponsored athletic event including a concussion.

ImPACT Neurocongnitive Testing

At the forefront of proper concussion management is the implementation of baseline and/or port-injury neurocongnitive testing. Such evaluation aims to objectively evaluate the concussed student athlete's post-injury cognitive status and help with tracking recovery for safe return to play, thus preventing the cumulative effects of concussion. ImPACT is a user friendly computer based testing program specifically designed for the management of sports-related concussion. ImPACT is currently the most widely utilized computerized program in the world and is implemented effectively across high school, collegiate and professional levels of sport participation. features of the ImPACT include:

- Measures players symptoms
- Computer administered, web-based
- Assist physicians and athletic trainers in making difficult return to play decisions
- Provides reliable baseline test information
- Produces comprehensive report of test results
- Automatically stores data from repeat testing
- Measure attention, memory, processing speed and reaction time
- Reaction time measured to 1/100th of a second

# EMERGENCY MEDICAL INFORMATION

Player's Name: _____

Parent's Name: _____

_____

Contact Phone Numbers: _____ - _____
Name Phone Number

_____ - _____
Name Phone Number

Person to contact if unable to reach parents:

_____ - _____ - _____
Name Phone Number Relationship

_____ - _____ - _____
Name Phone Number Relationship

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**MUST CHECK ONE (MUST BE FILLED OUT COMPLETELY!):**

☐ Insurance Company: _____
Policy Number: _____

☐ I would like to purchase school insurance.

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**If my son/daughter requires medical attention and the coaches are unable to reach the parents or guardian, they have my permission to seek emergency medical treatment.**

Parent's Signature: _____

Date: _____