



Jennifer Clark
Principal

Boyette Junior High School

59295 Rebel Drive
Slidell, Louisiana 70461
Phone (985) 643-3775
Fax (985) 649-9470



Carolyn Duffaut
Assistant Principal

I hereby give permission for my child, _____ to attend and participate in the athletic events as herein described.

Event: Boys Volleyball try-outs with season to follow
Coach/Sponsor/Teacher: Ryan Walsh
Time/Date: March 10th 4:00-5:30
Location: Boyette

Means of Transportation (Check one): ☒ Private Vehicle •see note below
☐ St. Tammany Parish School Bus/other (Please describe)

Before signing this form, please note that your signature will serve as a declaration that you have read, understood and agreed to the following:

- A. You must provide evidence of possession of insurance before a student will be allowed to tryout or participate in any athletic activity, dance team, or cheerleading squad.
- B. You must provide evidence of a current physical for your child: a current physical provided during the current school term (June - May 31). This must be done before a student will be allowed to tryout or participate in any athletic activity, dance team, or cheerleading squad.
- C. Your child must meet all athletic eligibility academic, and behavioral guidelines.
- D. You must have completed an emergency card to be filed with the sponsor/coach of the activity.
- E. You must secure your child within fifteen (15) minutes following the conclusion of the activity.
- F. I give permission for Boyette personnel and/or chaperones to seek/administer emergency medical aid for/to my child if they deem it necessary.
- G. I will not hold St. Tammany Parish School Board, Boyette Jr. High, Boyette administrators and/or faculty and/or the representative thereof responsible in the event of any accident during any and all aspects of the athletic activity.

Note: Before signing this form, please be certain that all your questions or concerns are addressed; you may contact the school at 985-643-3775.

Note: No ten (10) passenger vans/vehicles may be used to transport student to school activities.

Note: According to school board policy, owner of private vehicles that are used for school activities are primary insurance carriers.

Parent/Guardian Signature: _____ Date: _____

Activity Approval: For Administrative Use Only
 Date: 2-26-25

ATHLETIC EMERGENCY SHEET

STUDENT: _____ I.D.# _____

DATE OF BIRTH: _____

PARENT/GUARDIAN _____

TELEPHONE _____ WORK PHONE _____

Who will assume temporary care and responsibility for your child in the event of emergency:

1. NAME _____ PHONE: _____
2. NAME _____ PHONE: _____
3. NAME _____ PHONE: _____

LIST ANY ALLERGIES OR MEDICAL CONDITIONS:

- 1.
- 2.
- 3.
- 4.
- 5.

PROOF OF INSURANCE

1. Company: _____
2. Policy/Company/Card Number: _____
3. Expiration Date: _____

To Whom It May Concern: I give permission for Boyet Junior High School personnel to seek/administer emergency medical aid for my child as they deem necessary.

Parent/Guardian Signature

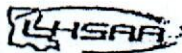
Louisiana High School Athletic Association
Parent and Student-Athlete Concussion Statement

- ☐ 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	



SCHOOL WAIVER FORM EXTRACURRICULAR ACTIVITIES

The St. Tammany Parish School Board, its employees, agents and insurers have no liability, and accepts 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.

Student's Name _____ Sports/Activities All Sports Sex M F
 School _____ Grade _____ Age _____ Date of Birth / / /
 Parent's/Guardian's Name _____
 Father's/Guardian's SS# XXX-XX Mother's/Guardian's SS# XXX-XX
 Work Address _____
 Phone Number () _____
 Home Address _____
 Phone Number () _____
 Another Person to Contact _____
 Relationship _____
 Insurance Company _____ Phone Number () _____
 Policy Number and/or Group Numbers _____
 ALLERGIES _____
 Parent's Signature _____ Student's Signature _____
 Date _____ (if over age 18)
 Date _____

IMPORTANT NOTICE — It is the policy of the 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 parents/guardians

LHSAA MEDICAL HISTORY EVALUATION

Page 1 of 2

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 Mononucleosis
☐	☐	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

LHSAA MEDICAL HISTORY EVALUATION

Page 2 of 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 _____
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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.

What are the signs and symptoms of a concussion?

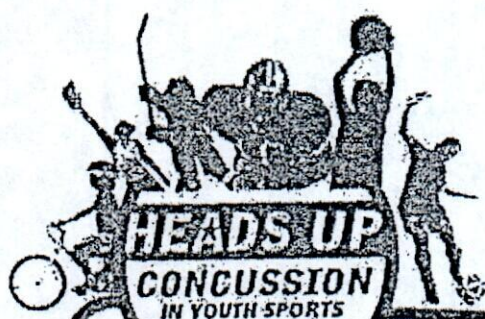
SIGNS OBSERVED BY PARENTS, FRIENDS, TEACHERS OR COACHES	SYMPTOMS REPORTED BY ATHLETE
Appears dazed or stunned	Is "fuzzy"
Is disoriented about what is going on	Nausea
Doesn't know his name	Balance problems
Is unsure about what he or she is doing	Double or blurry vision
Moves clumsily	Sensitivity to light or noise
Has trouble remembering	Feeling sluggish
Has trouble concentrating	Feeling irritable or moody
Shows a change in personality	Concentration or memory problems
Has trouble with school	Headaches

What should I do if I think my child has had a concussion?

If an athlete is suspected of having a concussion, he or she must be immediately removed from play, be it a game or practice. Continuing to participate in physical activity after a concussion can lead to worsening concussion symptoms, increased risk for further injury, and even death. Parents and coaches are not expected to be able to "diagnose" a concussion, as that is the job of a medical professional. However, you must be aware of the signs and symptoms of a concussion and if you are suspicious, then your child must stop playing:

When in doubt, sit them out!

All athletes who sustain a concussion need to be evaluated by a health care professional who is familiar with sports concussions. You should call your child's physician and explain what has happened and follow your physician's instructions. If your child is vomiting, has a severe headache, is having difficulty staying awake or answering simple questions he or she should be taken to the emergency department immediately.



A Fact Sheet for ATHLETES

WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a bump or blow to the head
- Can change the way your brain normally works
- Can occur during practices or games in any sport
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged"

WHAT ARE THE SYMPTOMS OF A CONCUSSION?

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion
- Does not "feel right"

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

- Tell your coaches and your parents. Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach if one of your teammates might have a concussion.

- Get a medical check up. A doctor or health care professional can tell you if you have a concussion and when you are OK to return to play.

- Give yourself time to get better. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Second or later concussions can cause damage to your brain. It is important to rest until you get approval from a doctor or health care professional to return to play.

HOW CAN I PREVENT A CONCUSSION?

Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Use the proper sports equipment, including personal protective equipment (such as helmets, padding, shin guards, and eye and mouth guards). In order for equipment to protect you, it must be:

- > The right equipment for the game, position, or activity
- > Worn correctly and fit well
- > Used every time you play

It's better to miss one game than the whole season.



A Parent's Guide to Concussion in Sports

What is a concussion?

- A concussion is a brain injury which results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. An athlete does not have to lose consciousness ("knocked-out") to suffer a concussion.

Concussion Facts

- It is estimated that over 140,000 high school athletes across the United States suffer a concussion each year. (Data from NFHS Injury Surveillance System)
 - Concussions occur most frequently in football, but girl's lacrosse, girl's soccer, boy's lacrosse, wrestling and girl's basketball follow closely behind. All athletes are at risk.
 - A concussion is a traumatic injury to the brain.
 - Concussion symptoms may last from a few days to several months.
 - Concussions can cause symptoms which interfere with school, work, and social life.
 - An athlete should not return to sports while still having symptoms from a concussion as they are at risk for prolonging symptoms and further injury.
 - A concussion may cause multiple symptoms. Many symptoms appear immediately after the injury, while others may develop over the next several days or weeks. The symptoms may be subtle and are often difficult to fully recognize.
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