

Monteleone Junior High

Home of the Marlins



Dear Parents:

In order for your child to participate in our Athletic program at Monteleone Junior High School, we need your permission in order for us to complete the requirements for his/her participation. These requirements are:

1. A physical exam
2. Health Insurance
3. Your permission for your child to play

Please complete the following form so that we know that all requirements have been met: My child has health insurance coverage, which will cover my child for Junior High Athletics.

_____ YES _____ NO (Please check one)

If yes, name of company and policy #: _____

If no, my child _____, will purchase insurance through the school before he/she can participate.

My child, _____, has my permission to participate in the Program at Monteleone Junior High School.

NO ONE WILL BE ALLOWED TO PARTICIPATE UNTIL PROOF OF INSURANCE IS PROVIDED. In addition to the above-mentioned requirements, we would like to point out a couple of other matters concerning athletics:

1. Your child is now involved in interscholastic sports. The competition is between schools with the intent to compete to the best of our ability as a team. Athletic selection and playing time will be based on skill level and who can best help the team. The coach has the final decision. Understand that this is different from recreational sports.
2. Parental support, concessions and the admission gate generated from games is how we support athletics. Without it we would not have a program. We need a great deal of help with concessions and with admissions. If everyone helps a little it won't be a burden to anyone. The coaches will have a sign-up sheet for each of the games. Please sign up early.

Sincerely,

Jennifer Westcott
Principal

Parent/Guardian
Signature

Jennifer Westcott, Principal

63000 BLUE MARLIN DRIVE, MANDEVILLE LA 70448

(985) 951-8088



Frank J. Jabbia
Superintendent

Steve E. Alfonso, Jr.
Assistant Superintendent

Kimberly B. Gardner
Assistant Superintendent

Mary Hart
Assistant Superintendent

Jeanne B. McCurley, Ph.D.
Assistant Superintendent

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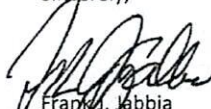
Dear Parent/Guardian:

The St. Tammany Parish School Board, its employees, agents and insurer's 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 and activities. The student and parent(s)/guardian(s) assume any and all risks, including without limitation of risk injury and risk of incurring medical expenses associated with the participation by the student.

The St. Tammany Parish School Board does not provide a base accident-medical expenses insurance plan for students, however, the School Board does provide a \$25,000.00 deductible catastrophic policy for all interscholastic athletes, including interscholastic football and cheerleaders and participants of non-sport extra-curricular activities. Details regarding provision of this plan are available through the School Board office. If you have a son or daughter participating in interscholastic sports or cheerleading, we recommend you investigate the following:

1. Check with your own health insurance carrier to determine the nature and extend of coverage available to you due to athletic injury.
2. If athletic injuries are not covered or only partially covered through your current health plan, consider purchasing a rider to that plan.
3. Contact the School's Athletic Department for information regarding an insurance plan designed for students that is offered at the beginning of the school year or throughout the year upon your request.

Sincerely,



Frank J. Jabbia
Superintendent

Learning to Last a Lifetime.®

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 _____ 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 _____ Phone Number () _____
Insurance Company _____
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.

SCHOOL WAIVER FORM
EXTRACURRICULAR ACTIVITIES

THIS DOCUMENT MUST BE SIGNED BY THE STUDENT AND BY THE STUDENT'S PARENT OR LEGAL CUSTODIAN BEFORE PARTICIPATION. STUDENTS MAY NOT PARTICIPATE WITHOUT THE STUDENT'S AND PARENT'S/LEGAL CUSTODIAN'S SIGNATURE.

PARENTS, LEGAL CUSTODIANS, OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. The student and parent/legal custodian recognize that participation in interscholastic athletics and related extracurricular activities involves some inherent risks for potentially severe injuries including, but not limited to, serious neck, head and spinal injuries, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, serious injury or impairment to other aspects of the body, or effects to the general health and well-being of the child, and in rare cases death. Although serious injuries are not common in supervised school athletic programs and related extracurricular activities, it is impossible to eliminate all risk. Because of these inherent risks, the student and their parent/legal custodian have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily.

I authorize medical treatment should the need arise for such treatment while I or my child/ward ("student") is under the supervision of the St. Tammany Parish School Board school. I consent to medical treatment for the student following an injury or illness suffered during practice and/or a contest. I understand that in the case of injury or illness requiring treatment by medical personnel and transportation to a health care facility, that a reasonable attempt will be made to contact the parent/legal custodian in the case of the student being a minor, but that, if necessary, the student will be treated and transported via ambulance to the nearest hospital. I further authorize the use or disclosure of my student's personally identifiable health information should treatment for illness or injury become necessary.

I understand all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further, I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day, written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required before the student is allowed to return to participation.

The student and parent/legal custodian individually and on behalf of the student, hereby irrevocably, and unconditionally release, acquit, and discharge, without limitation, the St. Tammany Parish School Board, its officers, agents, attorneys, representatives and employees (collectively, the "Releasees") from any and all losses, claims, demands, actions and causes of action, obligations, damages, and costs or expenses of any nature (including attorney's fees) that the student and/or legal custodian incur or sustain to person, property or both, which arise out of, result from, occur during or are otherwise connected with the student's participation in interscholastic athletics or sports and related extracurricular 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.

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 _____
 Sports _____ 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'S 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 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 actor 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	☐	☐
Lungs	☐	☐
Heart	☐	☐
Abdomen	☐	☐
Skin	☐	☐
Hernia	☐	☐

(if Needed)

COMMENTS: _____

OPTIONAL EXAMS:

VISION:
 L: _____ R: _____ Corrected: _____

DENTAL:

12345678910111213141516
 313029282726252423222120191817

ORTHOPAEDIC EXAM :

	Norm	Abnl
I. Spine / Neck		
Cervical	☐	☐
Thoracic	☐	☐
Lumbar	☐	☐
II. Upper Extremity		
Shoulder	☐	☐
Elbow	☐	☐
Wrist	☐	☐
Hand / Fingers		
III. Lower Extremity		
Hip	☐	☐
Knee	☐	☐
Ankle	☐	☐

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
Parent and Student-Athlete Concussion Statement**

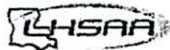
☐ I understand that it is my responsibility to report all injuries and illnesses to my coach, athletic trainer and/or team physician.

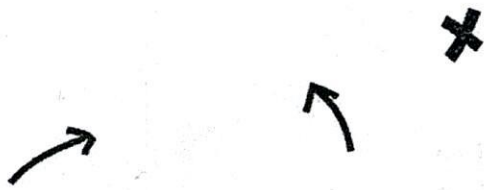
☐ I have read and understand the Concussion Fact Sheet.

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	





A FACT SHEET FOR

A concussion is a brain injury that:

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

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

You can't see a concussion, but you might notice *one or more* of the symptoms listed below or that you "don't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

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

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
 - The right equipment for the game, position, or activity
 - Worn correctly and the correct size and fit
 - Used every time you play or practice
- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

For more information and to order additional materials *free-of-charge*, visit: www.cdc.gov/Concussion.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION





A Fact Sheet for Parents

A concussion is a type of brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head. Concussions can also occur from a blow to the body that causes the head and brain to move rapidly back and forth. Even what seems to be a mild bump to the head can be serious.

Concussions can have a more serious effect on a young, developing brain and need to be addressed correctly.

You can't see a concussion. Signs and symptoms of concussion can show up right after an injury or may not appear or be noticed until hours or days after the injury. It is important to watch for changes in how your child or teen is acting or feeling, if symptoms are getting worse, or if s/he just "doesn't feel right." Most concussions occur without loss of consciousness.

If your child or teen reports *one or more* of the symptoms of concussion listed below, or if you notice the symptoms yourself, seek medical attention right away. Children and teens are among those at greatest risk for concussion.

SIGNS OBSERVED BY PARENTS OR GUARDIANS

Appears dazed or stunned
Is confused about events
Answers questions slowly
Repeats questions
Can't recall events *prior* to the hit, bump, or fall
Can't recall events *after* the hit, bump, or fall
Loses consciousness (even briefly)
Shows behavior or personality changes
Forgets class schedule or assignments

SYMPTOMS REPORTED BY YOUR CHILD OR TEEN

Thinking/Remembering:

Difficulty thinking clearly
Difficulty concentrating or remembering
Feeling more slowed down
Feeling sluggish, hazy, foggy, or groggy

Physical:

Headache or "pressure" in head
Nausea or vomiting
Balance problems or dizziness
Fatigue or feeling tired
Blurry or double vision
Sensitivity to light or noise
Numbness or tingling
Does not "feel right"

Emotional:

Irritable
Sad
More emotional than usual
Nervous

Sleep*:

Drowsy
Sleeps *less* than usual
Sleeps *more* than usual
Has trouble falling asleep

**Only ask about sleep symptoms if the injury occurred on a prior day.*

To download this fact sheet in Spanish, please visit: www.cdc.gov/Concussion. Para obtener una copia electrónica de esta hoja de información en español, por favor visitar: www.cdc.gov/Concusion.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION



DANGER SIGNS

Be alert for symptoms that worsen over time. Your child or teen should be seen in an emergency department right away if s/he has:

- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)

Children and teens with a concussion should **NEVER** return to sports or recreation activities on the same day the injury occurred. They should delay returning to their activities until a health care professional experienced in evaluating for concussion says they are symptom-free and it's OK to return to play. This means, until permitted, not returning to:

Physical Education (PE) class,
Sports practices or games, or
Physical activity at recess.

1. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion can determine how serious the concussion is and when it is safe for your child or teen to return to normal activities, including physical activity and school (concentration and learning activities).
2. **Help them take time to get better.** If your child or teen has a concussion, her or his brain needs time to heal. Your child or teen may need to limit activities while s/he is recovering from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse. After a concussion, physical and cognitive activities—such as concentration and learning—should be carefully managed and monitored by a health care professional.
3. **Together with your child or teen, learn more about concussions.** Talk about the potential long-term effects of concussion and the dangers of returning too soon to normal activities (especially physical activity and learning/concentration). For more information about concussion and free resources, visit: www.cdc.gov/Concussion.

Help your child or teen get needed support when returning to school after a concussion. Talk with your child's teachers, school nurse, coach, speech-language pathologist, or counselor about your child's concussion and symptoms. Your child may feel frustrated, sad, and even angry because s/he cannot return to recreation and sports right away, or cannot keep up with schoolwork. Your child may also feel isolated from peers and social networks. Talk often with your child about these issues and offer your support and encouragement. As your child's symptoms decrease, the extra help or support can be removed gradually. Children and teens who return to school after a concussion may need to:

Take rest breaks as needed,
Spend fewer hours at school,
Be given more time to take tests or
complete assignments,
Receive help with schoolwork, and/or
Reduce time spent reading, writing, or on
the computer.



To learn more about concussion and to order materials **FREE-OF-CHARGE**, go to: www.cdc.gov/Concussion or call 1.800.CDC.INFO.