

ARCHBISHOP RUMMEL HIGH SCHOOL

EXTRACURRICULAR STUDENT ATHLETE PACKET

Student's Name \_\_\_\_\_

Grade \_\_\_\_\_ Sport(s) \_\_\_\_\_

- \_\_\_\_\_ Student Information Questionnaire
- \_\_\_\_\_ Student Insurance Information
- \_\_\_\_\_ Medical Consent Form
- \_\_\_\_\_ Concussion Review
- \_\_\_\_\_ LHSAA Substance Abuse/Misuse Contract and Consent Form
- \_\_\_\_\_ LHSAA Athletic Participation/Parental Permission Form
- \_\_\_\_\_ LHSAA Medical History Evaluation
- \_\_\_\_\_ Physical Form Completed by a Licensed Physician

Please use this packet as a check list to ensure that all of the necessary athletic forms are completed. If all information is not completed and returned by the first day of practice your child WILL NOT be permitted to participate. Completed packets are due NO LATER THAN the first day of practice. Again, student athletes WILL NOT be permitted to begin practicing until packet is completed and returned to the coach or athletic trainer.

**NO EXCEPTIONS**

Completed packets may be mailed to the following address to ensure eligibility prior to the start of the athletic season:

*Athletic Director  
1901 Severn Avenue  
Metairie, LA 70001*

Athletes may bring completed packet with him to school on their scheduled physical date.

**IMPORTANT**

ALL LINES REQUIRING PARENT AND STUDENT SIGNATURES MUST BE SIGNED.

ARCHBISHOP RUMMEL HIGH SCHOOL  
Student Information Questionnaire

Student's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sport(s): \_\_\_\_\_

Grade: \_\_\_\_\_ Age: \_\_\_\_\_ **E-MAIL** \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Permanent Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

(F) Address: \_\_\_\_\_ (M) Address: \_\_\_\_\_

(F) Home Phone: \_\_\_\_\_ (M) Home Phone: \_\_\_\_\_

(F) Work Phone: \_\_\_\_\_ (M) Work Phone: \_\_\_\_\_

(F) Cell Phone: \_\_\_\_\_ (M) Cell Phone: \_\_\_\_\_

EMERGENCY NOTIFICATION INFORMATION

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone (H): \_\_\_\_\_ Phone (W): \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

MEDICATION INFORMATION

Medication taken regularly by student: \_\_\_\_\_

Instructions for Archbishop Rummel personnel regarding medication to be administered: \_\_\_\_\_

Does your child have allergies: \_\_\_\_\_ To what?: \_\_\_\_\_

Reaction: \_\_\_\_\_ Usual Treatment: \_\_\_\_\_

May school personnel administer to your child non-prescription medication, such as aspirin, Tylenol, pepto-bismol for minor ailments?: \_\_\_\_\_ Restrictions: \_\_\_\_\_

EMERGENCY RELEASE INFORMATION

In the event that any illness or injury occurs, and it is not possible to contact me or my designated physician, this will give authority to Archbishop Rummel High School to obtain emergency medical, surgical, or dental treatment for my child.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dear Parents:

Please provide proof of insurance for your child to the Athletic department. It is also important to identify the insurance carrier. This is necessary in the event of an emergency.

If a student is accidentally injured and generates medical expenses associated with the accident, all claims must be filed first with the parent's personal insurance company. If a balance remains after the personal insurance company has paid its maximum, that balance will be submitted to the school's athletic accident insurance company. If covered, the school's insurance company will pay the balance of the eligible medical expenses not covered by the parent's company, up to the maximum of the policy. Please note that the school's insurance coverage is secondary to the personal insurance company under which the student is covered.

The School's insurance coverage covers only new accidents that are sustained during competition or supervised practice.

The Athletic Director must be notified within 20 days of a student's injury. A form of notification of injury will be sent to the school's insurance company and a form with an explanation of procedure to the parents.

If you have any questions, please feel free to contact us at your earliest convenience.

Jay Roth

Athletic Director

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Please complete and return the following section along with the athletic packet:

I have read and understand the above information. My son, \_\_\_\_\_ is covered by:

Regular/Indemnity \_\_\_\_\_ PPO \_\_\_\_\_ HMO \_\_\_\_\_ Point of Service \_\_\_\_\_ Medicaid \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Name of Insurance Party: \_\_\_\_\_

Social Security Number of Insurance Party: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group Name or Number: \_\_\_\_\_

Signature of Parent \_\_\_\_\_ Date: \_\_\_\_\_

# ARCHBISHOP RUMMEL HIGH SCHOOL

## MEDICAL CONSENT FORM

Student-Athlete Name: \_\_\_\_\_

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above named student. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given.

In the event that an emergency arises during a practice session or an athletic competition, an effort will be made to contact the parents or guardians as soon as possible. Permission is also granted to the athletic trainer to provide the needed emergency treatment to the athlete prior to his admission to the medical facilities.

\_\_\_\_\_  
*Signature of Parent or Guardian*

\_\_\_\_\_  
*Date*

Telephone numbers where parents can be reached:

Name(s): \_\_\_\_\_

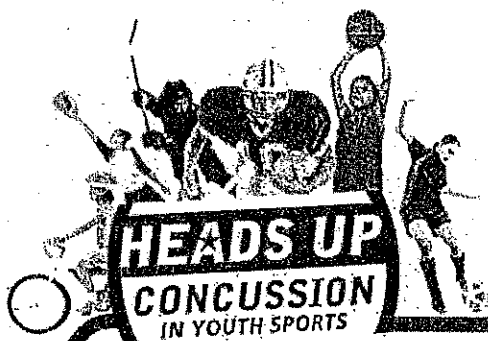
\_\_\_\_\_  
Name of Family Physician:

Office: \_\_\_\_\_

Home: \_\_\_\_\_

\_\_\_\_\_  
Phone: \_\_\_\_\_

Cell: \_\_\_\_\_



## A Fact Sheet for PARENTS

### WHAT IS A CONCUSSION?

A concussion is a brain injury. Concussions are caused by a bump or blow to the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

### WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

#### Signs Observed by Parents or Guardians

*If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:*

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

#### Symptoms Reported by Athlete

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Does not "feel right"

### HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION?

Every sport is different, but there are steps your children can take to protect themselves from concussion.

- Ensure that they follow their coach's rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity (such as helmets, padding, shin guards, and eye and mouth guards). Protective equipment should fit properly, be well maintained, and be worn consistently and correctly.
- Learn the signs and symptoms of a concussion.

### WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

1. **Seek medical attention right away.** A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to sports.
2. **Keep your child out of play.** Concussions take time to heal. Don't let your child return to play until a health care professional says it's OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a second concussion. Second or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.
3. **Tell your child's coach about any recent concussion.** Coaches should know if your child had a recent concussion in ANY sport. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

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

**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 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: 5-10-25

M. J. [Signature]  
Principal

Dated: 5-10-25

Jay Roeth  
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

## 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:

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

A school shall **only** be required to have this form completed and signed prior to **the first time**

**PARENTAL PERMISSION FORM**

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 ELIGIBILITY 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 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?

<b>Yes No Condition</b>	<b>Whom</b>	<b>Yes No Condition</b>	<b>Whom</b>
<input type="checkbox"/> <input type="checkbox"/> Heart Attack/Disease	_____	<input type="checkbox"/> <input type="checkbox"/> Sudden Death	_____
<input type="checkbox"/> <input type="checkbox"/> Stroke	_____	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> <input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> <input type="checkbox"/> Sickie Cell Trait/Anemia	_____
		<input type="checkbox"/> <input type="checkbox"/> Arthritis	_____
		<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	_____
		<input type="checkbox"/> <input type="checkbox"/> Epilepsy	_____

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

<b>Yes No Condition</b>	<b>Date</b>	<b>Yes No Condition</b>	<b>Date</b>
<input type="checkbox"/> <input type="checkbox"/> Head Injury / Concussion	_____	<input type="checkbox"/> <input type="checkbox"/> Neck Injury / Slinger	_____
<input type="checkbox"/> <input type="checkbox"/> Elbow L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Arm / Wrist / Hand L / R	_____
<input type="checkbox"/> <input type="checkbox"/> Hip L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Thigh L / R	_____
<input type="checkbox"/> <input type="checkbox"/> Lower Leg L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Chronic Shin Splints	_____
<input type="checkbox"/> <input type="checkbox"/> Foot L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Severe Muscle Strain	_____
<input type="checkbox"/> <input type="checkbox"/> Chest	_____		

Previous Surgeries: \_\_\_\_\_

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

<b>Yes No Condition</b>	<b>Yes No Condition</b>	<b>Yes No Condition</b>
<input type="checkbox"/> <input type="checkbox"/> Heart Murmur / Chest Pain / Tightness	<input type="checkbox"/> <input type="checkbox"/> Asthma / Prescribed Inhaler	<input type="checkbox"/> <input type="checkbox"/> Menstrual Irregularities: Last Cycle: _____
<input type="checkbox"/> <input type="checkbox"/> Seizures	<input type="checkbox"/> <input type="checkbox"/> Shortness of breath / Coughing	<input type="checkbox"/> <input type="checkbox"/> Rapid weight loss / gain
<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Hernia	<input type="checkbox"/> <input type="checkbox"/> Take supplements/vitamins
<input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> <input type="checkbox"/> Knocked out / Concussion	<input type="checkbox"/> <input type="checkbox"/> Heat related problems
<input type="checkbox"/> <input type="checkbox"/> Single Testicle	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Recent Mononucleos
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Enlarged Spleen
<input type="checkbox"/> <input type="checkbox"/> Dizzy / Fainting	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Sickie Cell Trait/Anemia
<input type="checkbox"/> <input type="checkbox"/> Organ Loss (Kidney, spleen, etc)	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Overnight in hospital
<input type="checkbox"/> <input type="checkbox"/> Surgery	<input type="checkbox"/> <input type="checkbox"/> Prescribed EPI PEN	<input type="checkbox"/> <input type="checkbox"/> Allergies (Food, Drugs) _____
<input type="checkbox"/> <input type="checkbox"/> 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 \_\_\_\_\_

### II. COMPLETED ANNUALLY BY MEDICAL DOCTOR (MD), OSTEOPATHIC DR. (DO), NURSE PRACTITIONER (APRN) or PHYSICIAN'S ASSISTANT (PA)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

<b>GENERAL MEDICAL EXAM :</b>			<b>ORTHOPAEDIC EXAM :</b>								
	<b>Norm</b>	<b>Abni</b>	<b>I. Spine / Neck</b>	<b>Norm</b>	<b>Abni</b>	<b>II. Upper Extremity</b>	<b>Norm</b>	<b>Abni</b>	<b>III. Lower Extremity</b>	<b>Norm</b>	<b>Abni</b>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	Cervical	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Knee	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Thoracic	<input type="checkbox"/>	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Hip	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	Hand / Fingers	<input type="checkbox"/>	<input type="checkbox"/>	Ankle	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>				Wrist	<input type="checkbox"/>	<input type="checkbox"/>			
Skin	<input type="checkbox"/>	<input type="checkbox"/>									

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 \_\_\_\_\_