

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: 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

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

ATHLETE MEDICAL HISTORY: Has the athlete had any of these conditions? Yes No Condition Yes No Condition Yes No Condition

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.

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.

- 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). 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: ENT Lungs Heart Abdomen Skin Hernia (if Needed) COMMENTS:
OPTIONAL EXAMS: VISION: L: R: Corrected: DENTAL: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
ORTHOPAEDIC EXAM: 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 one year from the date it was signed and dated by the MD, DO, APRN or PA.