LHSAA MEDICAL HISTORY EVALUATION IMPORTANT: This form must be completed <u>annually</u>, kept on file with the school, & is subject to inspection by the Rules Compliance Team. Please Print Name: School: Grade: Date: __Sex: M / F Date of Birth:_____Age:____Cell Phone:___ Sport(s):___ Home Address: _____ City: _____ State: __ Zip Code: ____ Home Phone: _____ ___Employer:___ Parent / Guardian: 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 Yes No Condition Date Yes No Condition Date Shoulder L / R ☐ ☐ Head Injury / Concussion □ □ Neck Injury / Stinger ☐ Arm / Wrist / Hand L / R Elbow L / R Back ☐ Hip L / R □ □ Thigh L / R Knee L / R □ □ Ankle L / R ☐ ☐ Chronic Shin Splints □ Lower Leg L / R ☐ Foot L / R □ □ Severe Muscle Strain □ □ Pinched Nerve П Previous Surgeries: Chest **ATHLETE MEDICAL HISTORY**: Has the athlete had any of these conditions? Yes No Condition Yes No Condition Yes No Condition ☐ Menstrual irregularities: Last Cycle: _______ ☐ ☐ Heart Murmur / Chest Pain / Tightness ☐ ☐ Asthma / Prescribed Inhaler Seizures Shortness of breath / Coughing Rapid weight loss / gain Kidney Disease Hernia Take supplements/vitamins ☐ ☐ Heat related problems Irregular Heartbeat □ □ Knocked out / Concussion Single Testicle Recent Mononucleosi Heart Disease Enlarged Spleen High Blood Pressure Diabetes Dizzy / Fainting Liver Disease □ Sickle Cell Trait/Anemia □ □ Overnight in hospital Organ Loss (kidney, spleen, etc) ☐ ☐ Tuberculosis 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 healthcare 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 No 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 **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) **GENERAL MEDICAL EXAM: OPTIONAL EXAMS: ORTHOPAEDIC EXAM:** Norm Abnl VISION: Norm Abnl **ENT** I. Spine / Neck Corrected: Lungs Cervical Heart DENTAL: Thoracic П Abdomen 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 Lumbar Skin 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 **II.** Upper Extremity Hernia Shoulder П (if Needed) Elbow COMMENTS: Wrist П П Hand / Fingers III. Lower Extremity diH From this limited screening I see no reason why this student cannot participate in athletics. Knee

Printed Name of MD, DO, APRN or PA

Signature of MD, DO, APRN or PA

Date of Medical Examination

Ankle

[] Student is cleared

[] Cleared after further evaluation and treatment for:_ [] Not cleared for: __contact __non-contact