

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
Heart Attack/Disease
Stroke
Diabetes
Sudden Death
Arm / Wrist / Hand L / R
Sickle Cell Trait/Anemia
Arthritis
Kidney Disease
Epilepsy

ATHLETE'S ORTHOPAEDIC HISTORY: Has the athlete had any of the following injuries?
Yes No Condition Date
Head Injury / Concussion
Elbow L / R
Hip L / R
Lower Leg L / R
Foot L / R
Chest
Neck Injury / Stinger
Arm / Wrist / Hand L / R
Thigh L / R
Chronic Shin Splints
Severe Muscle Strain
Shoulder L / R
Back
Knee L / R
Ankle L / R
Pinched Nerve

ATHLETE MEDICAL HISTORY: Has the athlete had any of these conditions?
Yes No Condition
Heart Murmur / Chest Pain / Tightness
Seizures
Kidney Disease
Irregular Heartbeat
Single Testicle
High Blood Pressure
Dizzy / Fainting
Organ Loss (kidney, spleen, etc)
Surgery
Medications
Asthma / Prescribed Inhaler
Shortness of breath / Coughing
Hernia
Knocked out / Concussion
Heart Disease
Diabetes
Liver Disease
Tuberculosis
Prescribed EPI PEN
Menstrual irregularities: Last Cycle:
Rapid weight loss / gain
Take supplements/vitamins
Heat related problems
Recent Mononucleosi
Enlarged Spleen
Sickle Cell Trait/Anemia
Overnight in hospital
Allergies (Food, Drugs)

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
OPTIONAL EXAMS: VISION, DENTAL
ORTHOPAEDIC EXAM: I. Spine / Neck, II. Upper Extremity, III. Lower Extremity

COMMENTS:

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 on the last day of the month that it was signed and dated by the MD, DO, APRN or PA.