

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?

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 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 Mononucleosi
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 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

Health Care Provider section on page 2

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 School: _____ Grade: _____ Sport(s): _____

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

Height _____	Weight _____	Blood Pressure _____	Pulse _____
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GENERAL MEDICAL EXAM :

	Norm	Abnl
ENT	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>

ORTHOPAEDIC EXAM :

I. Spine / Neck

	Norm	Abnl
Cervical	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>

II. Upper Extremity

	Norm	Abnl
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>
Hand / Fingers	<input type="checkbox"/>	<input type="checkbox"/>
Wrist	<input type="checkbox"/>	<input type="checkbox"/>

III. Lower Extremity

	Norm	Abn
Knee	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>
Ankle	<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
 North Oaks Pediatric Clinic
 42440 Pelican Professional Park
 Hammond, LA 70403

Signature of MD, DO, APRN or PA

Date of Medical Examination

Revised 5/23

This physical expires 13 months from the date it was signed and dated by the MD, DO, APRN or PA.