LHSAA MEDICAL HISTORY EVALUATION

MPORTANT: This form must be completed *annually*, kept on file with the school, & is subject to inspection by the Rules Compliance Team.

Please Print

lame:______________________ School:______________________ Grade:______ Date:__________

port(s):______________________ Sex: M / F Date of Birth:__________ Age:_____ Cell Phone:__________

lome Address:______________________ City:______________ State:____ Zip Code:________ Home Phone:__________

arent / Guardian:______________________ Employer:______________________ Work Phone:__________

AMILY 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	______

THLETE'S 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: ______					

THLETE 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 valuation 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 xamination 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-are 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 tudent 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 aused 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 as 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) .... **Yes** **No**

______________________ ______________________ ______________________

ate Signed by Parent **Signature of Parent** **Typed or Printed Name of Parent**

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

Height __________ Weight __________ Blood Pressure __________ Pulse__________

ENERAL MEDICAL EXAM :

	Norm	Abnl
NT	☐	☐
ungs	☐	☐
eart	☐	☐
bdomen	☐	☐
kin	☐	☐
ernia *(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 :

	Norm	Abnl
I. Spine / Neck		
Cervical	☐	☐
Thoracic	☐	☐
Lumbar	☐	☐
II. Upper Extremity		
Shoulder	☐	☐
Elbow	☐	☐
Wrist	☐	☐
Hand / Fingers		
III. Lower Extremity		
Hip	☐	☐
Knee	☐	☐
Ankle	☐	☐

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

ised 6/18