To Football Players and Managers:

You will be given a **Physical Form** for football. This form will be completed by your family doctor as part of your physical examination.

Also, you will be given an **Emergency Information Sheet.** This is also to be completed and brought back along with your physical.

All football players and managers are to report on ***Wednesday, July, 18th*** between ***11:00 A.M. and 1:00 P.M.*** in the school auditorium. At that time, you are to bring with you both completed forms. Also, you are to have at least one parent there with you to sign the insurance waiver form. This will indicate whether or not you want to purchase the school insurance or be covered under your family insurance. If you choose to take the school insurance, it must be purchased at that time. If you choose to not take the school insurance, a copy of your current insurance card is required.

Football packets will be purchased that day at the cost of **$80.**
This includes:

A) short $20
B) shirt $20
C) football bag $20
D) numbered practice jersey $20

All players must purchase their own shoes and socks.

All other equipment, helmet, shoulder pads, game jerseys, etc.
WILL BE PROVIDED BY THE SCHOOL

Practice will begin ***WEDNESDAY, JULY 25, from 3:00 to 5:00.***

BE PREPARED AND IN SHAPE

See you then,

Coach Curole

Coach Curole

To Volleyball Players and Managers:

You will be given a **Physical Form** for volleyball. This form will be completed by your family doctor as part of your physical examination.

Also, you will be given an **Emergency Information Sheet.** This is also to be completed and brought back along with your physical.

All volleyball players and managers are to report on ***Wednesday, July, 18th*** between ***11:00 A.M. and 1:00 P.M.*** in the school auditorium. At that time, you are to bring with you both completed forms. Also, you are to have at least one parent there with you to sign the insurance waiver form. This will indicate whether or not you want to purchase the school insurance or be covered under your family insurance. If you choose to take the school insurance, it must be purchased at that time. If you choose to not take the school insurance, a copy of your current insurance card is required.

Tryout Dates:
Tuesday, July 31 from 9:00 a.m. to 10:30 a.m.
Wednesday, August 1 from 9:00 a.m. to 10:30 a.m.
Thursday, August 2 from [redacted]9:00 a.m. to 10:30 a.m.

***Reminder: All players must be properly equipped with shoes, socks, and knee pads.**

See you then,

Coach Sanders

Coach Sanders

New 2018 physical *

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
☐	☐	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	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) ..... 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 :

	Norm	Abnl
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 :

	Norm	Abnl
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.

Revised 4/18

Emergency Information

Athletic Department
Emergency Information and Parent Consent

General Information:

Athlete's Name: _____ Date of Birth: _____

Mailing Address: _____ City: _____

Parent's Name: _____ Home Phone No.: _____

Parent's Employer: _____ Work Phone No.: _____

Insurance Company: _____ Policy # _____

In an emergency, if the parents cannot be reached, notify:

Name: _____ Phone No.: _____

Name: _____ Phone No.: _____

Health Information:

Family Doctor: _____ Phone No.: _____

Family Dentist: _____ Phone No.: _____

Known Allergies: _____

Current Medications: _____

Answer YES or NO to the following: (If yes, please explain on back of sheet)

Asthma: _____ *Inhaler:* _____ *Concussion:* _____

Diabetic: _____ *Skin Problems:* _____ *Seizure:* _____

Consent Forms:

In an emergency, I give permission for the coach, athletic trainer and/or team physician to use their judgment in securing medical care and/or an ambulance.

Also, permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the above-named student; in the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury. I understand that an attempt will be made by attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

Parent/Guardian Signature _____ **Date** _____

I give permission for the school athletic trainer (coach) to speak with physician(s) regarding my child's health status as it pertains to athletic participation.

Parent/Guardian Signature _____ **Date** _____

I give permission for coaches, athletic director, principal, and guidance councilors to give copies of my child's transcript to college coaches and/or college recruiters.

Parent/Guardian Signature _____ **Date** _____ 25-G