**LHSAA MEDICAL HISTORY EVALUATION**



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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Name:_____ Date of Birth:_____ Age:_____ Date:_____
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_____

**GENERAL MEDICAL EXAM :**
**Norm Abnl**
ENT
Lungs
Heart
Abdomen
Skin

**ORTHOPAEDIC EXAM :**

**I. Spine / Neck II. Upper Extremity III. Lower Extremity**

**Norm Abnl Norm Abnl Norm Abn** Cervical Shoulder Knee
Thoracic Elbow Hip
Lumbar Hand / Fingers Ankle Wrist

*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 Signature of MD, DO, APRN or PA Date of Medical Examination and dated by the MD, DO, APRN or PA.**

*Revised 5/23*
**This physical expires 13 months from the date it was signed**