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
☐	☐	Heart Attack/Disease	
☐	☐	Stroke	
☐	☐	Diabetes	
☐	☐	Sudden Death	
☐	☐	High Blood Pressure	
☐	☐	Sickle Cell Trait/Anemia	
☐	☐	Arthritis	
☐	☐	Kidney Disease	
☐	☐	Epilepsy	

ATHLETE 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	

Previous Surgeries: _____

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 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 t 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 dam 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

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

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

	Norm	Abnl
Cervical	☐	☐
Thoracic	☐	☐
Lumbar	☐	☐

II. Upper Extremity

	Norm	Abnl
Shoulder	☐	☐
Elbow	☐	☐
Hand / Fingers	☐	☐
Wrist	☐	☐

III. Lower Extremity

	Norm	Abn
Knee	☐	☐
Hip	☐	☐
Ankle	☐	☐

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**

Revised 5/23 **This physical expires 13 months from the date it was signed and dated by the MD, DO, APRN or PA.**