



LHSAA MEDICAL HISTORY EVALUATION
Sports Physical Consent & Clearance

School Clinic Name: _____
School Term: _____

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?

Table with 4 columns: Yes No Condition Whom. Rows include Heart Attack/Disease, Stroke, Diabetes, Sudden Death, High Blood Pressure, Sickle Cell Trait/Anemia, Arthritis, Kidney Disease, Epilepsy.

ATHLETE'S ORTHOPAEDIC HISTORY: Has the athlete had any of the following injuries?

Table with 4 columns: Yes No Condition Date. Rows include 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, Ankle L / R, Foot L / R, Severe Muscle Strain, Chest, Previous Surgeries, Pinched Nerve.

ATHLETE MEDICAL HISTORY: Has the athlete had any of these conditions?

Table with 3 columns: Yes No Condition. Rows include 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.

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.

- 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 :

Table with 3 columns: Norm, Abnl. Rows include ENT, Lungs, Heart, Abdomen, Skin, Hernia.

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 :

Table with 3 columns: Norm, Abnl. Rows include Spine / Neck (Cervical, Thoracic, Lumbar), Upper Extremity (Shoulder, Elbow, Wrist, Hand / Fingers), Lower Extremity (Hip, Knee, Ankle).

COMMENTS: _____

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 on the last day of the month that it was signed and dated by the MD, DO, APRN or PA.