

**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  |
|--------------------------|--------------------------|----------------------|-------|--------------------------|--------------------------|--------------------------|-------|--------------------------|--------------------------|----------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack/Disease | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sudden Death             | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis      | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke               | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Arm / Wrist / Hand L / R | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes             | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Trait/Anemia | _____ | <input type="checkbox"/> | <input type="checkbox"/> | 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  |
|--------------------------|--------------------------|--------------------------|-------|---------------------------|--------------------------|--------------------------|-------|--------------------------|--------------------------|----------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Head Injury / Concussion | _____ | <input type="checkbox"/>  | <input type="checkbox"/> | Neck Injury / Stinger    | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Shoulder L / R | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow L / R              | _____ | <input type="checkbox"/>  | <input type="checkbox"/> | Arm / Wrist / Hand L / R | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Back           | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip L / R                | _____ | <input type="checkbox"/>  | <input type="checkbox"/> | Thigh L / R              | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Knee L / R     | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Lower Leg L / R          | _____ | <input type="checkbox"/>  | <input type="checkbox"/> | Chronic Shin Splints     | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Ankle L / R    | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot L / R               | _____ | <input type="checkbox"/>  | <input type="checkbox"/> | Severe Muscle Strain     | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Pinched Nerve  | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest                    | _____ | Previous Surgeries: _____ |                          |                          |       |                          |                          |                |       |

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

| Yes                      | No                       | Condition                             | Yes                      | No                       | Condition                      | Yes                      | No                       | Condition                                   |
|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur / Chest Pain / Tightness | <input type="checkbox"/> | <input type="checkbox"/> | Asthma / Prescribed Inhaler    | <input type="checkbox"/> | <input type="checkbox"/> | Menstrual irregularities: Last Cycle: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures                              | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath / Coughing | <input type="checkbox"/> | <input type="checkbox"/> | Rapid weight loss / gain                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease                        | <input type="checkbox"/> | <input type="checkbox"/> | Hernia                         | <input type="checkbox"/> | <input type="checkbox"/> | Take supplements/vitamins                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat                   | <input type="checkbox"/> | <input type="checkbox"/> | Knocked out / Concussion       | <input type="checkbox"/> | <input type="checkbox"/> | Heat related problems                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Single Testicle                       | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease                  | <input type="checkbox"/> | <input type="checkbox"/> | Recent Mononucleosi                         |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure                   | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                       | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged Spleen                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizzy / Fainting                      | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease                  | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Trait/Anemia                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Organ Loss (kidney, spleen, etc)      | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis                   | <input type="checkbox"/> | <input type="checkbox"/> | Overnight in hospital                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery                               | <input type="checkbox"/> | <input type="checkbox"/> | Prescribed EPI PEN             | <input type="checkbox"/> | <input type="checkbox"/> | Allergies (Food, Drugs) _____               |
| <input type="checkbox"/> | <input type="checkbox"/> | 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,

- 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**
- 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**
- 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**
- 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         | <input type="checkbox"/> | <input type="checkbox"/> |
| Lungs       | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart       | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdomen     | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin        | <input type="checkbox"/> | <input type="checkbox"/> |
| Hernia      | <input type="checkbox"/> | <input type="checkbox"/> |
| (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                     |
|-----------------------------|--------------------------|--------------------------|
| <b>I. Spine / Neck</b>      |                          |                          |
| Cervical                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Thoracic                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Lumbar                      | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>II. Upper Extremity</b>  |                          |                          |
| Shoulder                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Elbow                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Wrist                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Hand / Fingers              |                          |                          |
| <b>III. Lower Extremity</b> |                          |                          |
| Hip                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Knee                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Ankle                       | <input type="checkbox"/> | <input type="checkbox"/> |

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.**