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

*Revised 5/14*