Scan and email to athletes@loyolaprep.org

# 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**

**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.

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.**

# STUDENT ATHLETE CONSENT FOR TREATMENT AND CARE

I, _____, parent or guardian of _____ recognize that as a result of athletic participation, medical treatment on an emergency or non-emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for such medical care. I do hereby authorize in advance to such emergency and non-emergency care, including hospital care, as may be deemed necessary under the then existing circumstances. The purpose of this release is to authorize the school to obtain, through a physician of its choice, any medical care that may become reasonably necessary for the student in the course of school athletic activities or school travel.

Additionally, I give my permission and consent for the evaluation and treatment of my child by the physicians at the CHRISTUS Health System, including CHRISTUS Saturday Sports Injury Clinic.

I hereby consent to and permit CHRISTUS Trinity Clinic Physicians/Staff (and/or their designee) to provide evaluation, medical treatment (including emergent or urgent treatment if necessary) to me/my child, including hospitalization and physician follow-up according to their medical judgment at the CHRISTUS Health System and/or its Saturday Morning Sports Injury Clinic.

I further authorize CHRISTUS Health System to obtain and release personal medical/insurance data about me for treatment payment or operations related to my injury, illness, physical examination(s) in accordance with the applicable state and federal privacy laws.

I am of sound mind and competent to sign this form.

I have read this form, understand it and agree to the terms and conditions.

_____ _____

Parent/Legal Guardian signature Date

_____ _____

Student/Athlete (if 18 years of age or older) Date

# STUDENT ATHLETE PRIVACY FORM
## Authorization for
## Disclosure of Protected Health Information

I, _____, parent or guardian of _____ (the "student athlete"), hereby authorize the physicians, athletic trainers, sports medicine staf f and other health care personnel represent CHRISTUS Health to release information regarding the student athlete's protected health information and related information regarding any i njury or illness during the student athlete's training for and participation in athletics at _____ School (the "School"). This protected health information may concern the student athlete's medical status, medical condition, injuries, prognosis, diagnos is, athletic participation status, and related individually identifiable health information. This protected health information may be released to other health care providers, hospitals and/or medical clinics, Saturday Morning Clinics, and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators, chaplains and/or clergy members, and offici als of _____ College or the _____ High School.

I understand that as a parent/legal guardian my authorization/consent to the disclosure of the student athlete's protected health information is a condition for the student athlete's participation in sports at the School. I understand that the student athlete's protected health information is pro tected under federal law. I, the parent/legal guardian, understand that once information is disc losed per this authorization, the information is subject to re-disclosure by the recipient and may n o longer be protected under federal law. I may revoke this authorization at any time by notifyin g the School's athletic director in writing, but if I do, it will not have any effect on actions taken i n reliance of my prior authorization. This authorization expires one year from the date it is signe d.

**REQUIRED SIGNATURE FOR PARTICIPATION FOR INTERSCHOLASTIC SPORTS**

_____ _____

Print Student Athlete Name Signature of Parent/Legal Guardian

_____

Date

**NOTICE OF PRIVACY PRACTICES**

**By signing above I acknowledge that I have received or have been offered a copy of CHRISTUS Health's Notice of Privacy Practices.**

## EXHIBIT B

## FORM OF ACKNOWLEDGEMENT AND RELEASE

### Sport Injury Evaluation Consent

I consent for a licensed Athletic Trainer from CHRISTUS to provide athletic training services within the Athletic Trainer's scope of license to _____ (Athlete). I am the Athlete's (circle one) parent / guardian / other: _____. Athletic Training services include administering first aid for athletic injuries, providing initial treatment and management of these injuries, and assessing athletic injuries at the request of the Athlete, the Athlete's coach, or the Athlete's parent/guardian. This consent is given voluntarily and is not a requirement for the Athlete to participate i n sports programs.

The Athletic Trainer will perform only those procedures that are within his/her training, credential limitations and scope of professional practice to prevent, care for and rehabilitate athletic injuries. A written report of any athletic injury assessment for the Athlete will be confidentially maintained and stored in a secure manner that allows access to authorized personnel only.

The Athletic Trainer is employed by CHRISTUS and is not employed or under the direction or control of _____ (School)

I authorize the Athletic Trainer who provides services to the Athlete to disclose information about the Athlete's injury assessments and post-injury status, to the involved coaching staff, any treating health care provider or consulting concussion management specialist. I will not be charged for the above listed athletic training services.

If the Athlete needs further treatment by a physician or other health care providers, including rehabilitation services for the injury, he or she should see the physician or provider of his/her choice. Although the Athletic Trainer is affiliated with CHRISTUS, there is no obligation to use a CHRISTUS facility or CHRISTUS affiliated provider. Prior to the performance of any services under this Agreement, CHRISTUS will instruct the Athletic Trainer, if asked to recommend a health care provider, to affirmatively inform the requester that he or she is free to choose any provider, regardless of location or affiliation. Injured athletes who have been evaluated or treated by a physician must submit written clearance from that physician to the Athletic Trainer and heal coach prior to the athlete being permitted to resume activity.

If the Athlete has been removed from play because of a suspected injury or concussion, the Athlete will not be permitted to return to play until the Athlete is evaluated by a health care provider, receives medical clearance and written authorization to return to play from that provider. This Consent will remain in effect for one sports season beginning with the date set forth below.

Student Athlete's Name: _____

_____

Signature of Athlete's parent / guardian / other: _____ (circle one)

Date: _____