LHSAA MEDICAL HISTORY EVALUATION

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	_____	□	□	Sudden Death	_____	□	□	Arthritis	_____
□	□	Stroke	_____	□	□	Heart Disease / High 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	□	□	Hernia
□	□	Seizures	□	□	Shortness of breath / Coughing	□	□	Prescribed Epi-Pen
□	□	Kidney Disease	□	□	Seizures	□	□	Rapid weight loss / gain
□	□	Irregular Heartbeat	□	□	Knocked out / Concussion	□	□	Take supplements / vitamins
□	□	Single Testicle	□	□	Heart Disease	□	□	Heat related problems
□	□	High Blood Pressure	□	□	Diabetes	□	□	Menstrual irregularities
□	□	Dizzy / Fainting	□	□	Liver Disease	□	□	Recent Mononucleosis
□	□	Organ Loss (kidney, spleen, etc)	□	□	Tuberculosis	□	□	Enlarged Spleen
□	□	Surgery	□	□	Overnight in hospital	□	□	Sickle Cell Trait/Anemia
□	□	Prescribed EPI PEN	□	□	Medications _____			
□	□	Allergies (Food, Drugs) _____	Date of last Tetanus Immunization _____					

WAIVER FORM

To the best of our knowledge, we have given true and accurate information and we 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 healthcare provider and/or employer under Louisiana law.

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**

This waiver, executed this ____ day of _____, 20___, by _____, M.D., D.O., RNP or PA and _____, patient, is executed 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.

_____ Typed or Printed Name of Student Athlete

_____ Signature of Parent

_____ Typed or Printed Name of Parent

Information below to be filled out by physician only

Height _____Weight _____
Blood Pressure_____Pulse_____

Orthopaedic Exam

	Norm	Abnl
I. Spine / Neck	□	□
Cervical	□	□
Thoracic	□	□
Lumbar	□	□
II. Upper Extremity	□	□
Shoulder	□	□
Elbow	□	□
Wrist	□	□
Hand / Fingers	□	□
III. Lower Extremity	□	□
Hip	□	□
Knee	□	□
Ankle	□	□

General Medical Exam

	Norm	Abnl		Norm	Abnl
ENT	□	□	Lungs	□	□
Heart	□	□	Abdomen	□	□
Skin	□	□	Hernia (if Needed)	□	□

General Health Comment's _____

Comments_____

OPTIONAL EXAMS

DENTAL
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
Comments_____

VISION L:_____ R:_____ Corrected: _____
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

_____ Typed or Printed Name of Physician

_____, **M.D.** **Signature of Physician**

_____ **Date**

*** This physical expires one year on the last day of the month that it was signed and dated by the physician. ***