

Saint Paul's School – Sports Eligibility Packet

ATTENTION PARENTS:

Please find attached the paperwork that is required annually by the LHSAA for your child to be eligible to play sports in Louisiana. It is very important that all sections are filled out completely. If any form is missing signatures or dates, we will be required to return the forms to you delaying your child's ability to participate in practice or games. The last four digits of the child's **Social Security** number are required for registering your child with the LHSAA.

If you have questions, please contact Claire Coutrado, Athletic Secretary, at clairec@stpauls.com or (985) 327-1848. Our goals are to keep files up-to-date, and to keep the boys involved.

RETURNING ATHLETES ARE REQUIRED TO SUBMIT ONLY THE FOLLOWING DOCUMENTS:

1. LHSAA Medical History Evaluation

The top of this form and the Parent's Waiver is to be filled out and signed by parents and Section II, the bottom of the form, is to be filled out by the physician conducting the physical. Physicals are valid for one year from date obtained.

2. St. Paul's School – Emergency Information

It is important that we have updated information completed annually so that we can contact you if your child is injured while under our care. It also gives us permission to have your child treated if immediate attention is needed before you are available. Please include updated insurance information.

Thank you for your help.

We look forward to another year of athletic success at St. Paul's school.

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 Back
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.

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 :

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

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

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 from the date it was signed and dated by the MD, DO, APRN or PA.

ST. PAUL'S SCHOOL - EMERGENCY/STUDENT INFORMATION FOR ATHLETES

STUDENT NAME: _____

PARENT/GUARDIAN: _____

STREET ADDRESS: _____

CITY/STATE/ZIP CODE: _____

HOME PHONE #: _____ STUDENT CELL: _____

MOM EMAIL ADDRESS: _____

DAD EMAIL ADDRESS: _____

STUDENT SS# (last 4 digits): _____ BIRTHDATE: _____
(student)

DAD CELL PHONE #: _____ DAD WORK #: _____

MOM CELL PHONE #: _____ MOM WORK #: _____

EMERGENCY NAME: _____
(other than parent)

EMERGENCY PHONE #: _____

INSURANCE CO. NAME: _____

INSURANCE GROUP #: _____

INSURANCE MEMBER ID #: _____

INSURANCE PHONE #: _____

ALLERGIES (IF ANY): _____

MEDICAL CONDITION(S): _____

INJURIES OR RESTRICTIONS: _____

MEDICINE TAKING CURRENTLY: _____

*** I hereby consent for a qualified physician or surgeon to examine and prescribe or perform treatment, including surgery that is deemed advisable for the welfare of the above named student-athlete.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____