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.
3. **LCMC Consent to Treatment and Waiver Liability Form**
   Beginning with the 2018-19 school year our athletic trainers are provided by LCMC Sports Medicine Group. This form gives them permission for treatment.
4. **LCMC OTC Permission form**
   This will allow our trainers to give over the counter medicine to your son if needed.
   Thank you for your help.

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	_____	☐	☐	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 13 months from the date it was signed and dated by the MD, DO, APRN or PA.

Revised 6/18

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: _____

Consent to Treatment and Waiver of Liability Form

I, _____ (parent/guardian) of _____ (student/athlete), understand that LCMC Sports Medicine (Children's Hospital, New Orleans East Hospital, Touro Infirmary, West Jeff Medical Center, and University Medical Center) provides athletic training, first aid and certain other medical services in connection with certain athletic events and programs of _____St. Paul's School_____ (School/Event). In case of emergency or accident on the school grounds or during any school activity involving the student designated below, which in the opinion of school authorities or personnel of LCMC Sports Medicine requires immediate medical attention, I hereby grant permission to such school authorities and LCMC Sports Medicine personnel to render medical care and to obtain the services of qualified medical personnel to treat the condition unless I am present and request otherwise or until revoked.

I also hereby release and agree to hold harmless all entities of LCMC Sports Medicine, their employees and agents, including, but not limited to, the Athletic Trainers from any and all liability in case of accident, injury, damage or other mishap in conncetion with all medical servies or athletic trainer services they provide the student.

_____ _____

Student Name AND Signature Date

_____ _____

Parent/Guardian Name AND Signature Date

_____

Parent/Guardian Phone Number

Parental Permission to Administer Over-The-Counter (OTC) Medication to Minors

Student Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Email: _____ Cellphone: _____

Please list any allergies: _____

Please list any long-term medication(s) taken and the reason for taking the listed medication(s):

_____

I, _____ (Parent/Guardian Name), by below signature, hereby hold the certified athletic trainer, NOEH, and St. Paul's School harmless in the administration of prepackaged, non-prescription OTC medications to the above listed student. I understand the certified athletic trainer will provide the medication in single dose only under a medical doctor's oversight. No medication will be given for long term use (longer than 3 consecutive days). NOEH, St. Paul's School and the certified athletic trainer accept no responsibility for OTC medications that are defective, either by their design or dosage recommendations, or are misused by the athlete. The misuse of medications will result in the athlete's loss of medication privileges. OTC Medications include:

- Motrin (ibuprofen)
- Tylenol (acetaminophen)
- Imodium (Loperamide)
- Heat Guard/Medi-Lyte (electrolytes)
- TUMS (bismuth subsalicylate)
- Glutose (glucose) *Only in case of identified diabetic necessity*
- Benadryl (diphenhydramine HCL) *Only in case of identified allergic reaction*

Parent/Guardian Signature: _____ Date: _____

This authorization shall remain effective until the end of the 2019-2020 school year.