

De La Salle High School Physical Date ***Student Athletic Physical Packet***

PLEASE READ AND COMPLETE ALL INFORMATION BEFORE RETURNING.
WE WILL NEED A COPY OF STUDENTS BIRTH CERTIFICATE AT THE TIME OF PHYSICAL.

- _____ LHSAA Medical History Evaluation/Physical Exam
(page 1)
- _____ LHSAA Athletic Participation/Parental Permission
(page 2-3)
- _____ LHSAA Substance Abuse/Misuse Contract and Consent
(page 4)
- _____ LHSAA Parent & Student Athlete Concussion Statement
(page 5)
- _____ Concussion Facts for Parents & Athletes(detach and keep)
(page 6-7)
- _____ Parental Permission to Administer Medication to Minors
(page 8)
- _____ **Copy Of Birth Certificate**

NOTICE

Please use this cover sheet as a checklist to ensure that all of the necessary athletic forms are completed. All information must be completed before your child can participate in any practice or activity associated with any sport here at De La Salle High School. The athlete should have all forms filled out by his/her parent/guardian prior to the day of physical examination.

Student athletes who do receive their physical examination outside of De La Salle High School Physical Day must still complete all forms.

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
<input type="checkbox"/> <input type="checkbox"/> Heart Attack/Disease	_____	<input type="checkbox"/> <input type="checkbox"/> Sudden Death	_____	<input type="checkbox"/> <input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> <input type="checkbox"/> Stroke	_____	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> <input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Trait/Anemia	_____	<input type="checkbox"/> <input type="checkbox"/> 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
<input type="checkbox"/> <input type="checkbox"/> Head Injury / Concussion	_____	<input type="checkbox"/> <input type="checkbox"/> Neck Injury / Stinger	_____	<input type="checkbox"/> <input type="checkbox"/> Shoulder L / R	_____
<input type="checkbox"/> <input type="checkbox"/> Elbow L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Arm / Wrist / Hand L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Back	_____
<input type="checkbox"/> <input type="checkbox"/> Hip L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Thigh L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Knee L / R	_____
<input type="checkbox"/> <input type="checkbox"/> Lower Leg L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Chronic Shin Splints	_____	<input type="checkbox"/> <input type="checkbox"/> Ankle L / R	_____
<input type="checkbox"/> <input type="checkbox"/> Foot L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Severe Muscle Strain	_____	<input type="checkbox"/> <input type="checkbox"/> Pinched Nerve	_____
<input type="checkbox"/> <input type="checkbox"/> Chest	_____	Previous Surgeries: _____			

ATHLETE MEDICAL HISTORY: Has the athlete had any of these conditions?

Yes No Condition	Yes No Condition	Yes No Condition
<input type="checkbox"/> <input type="checkbox"/> Heart Murmur / Chest Pain / Tightness	<input type="checkbox"/> <input type="checkbox"/> Asthma / Prescribed Inhaler	<input type="checkbox"/> <input type="checkbox"/> Menstrual irregularities: Last Cycle: _____
<input type="checkbox"/> <input type="checkbox"/> Seizures	<input type="checkbox"/> <input type="checkbox"/> Shortness of breath / Coughing	<input type="checkbox"/> <input type="checkbox"/> Rapid weight loss / gain
<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Hernia	<input type="checkbox"/> <input type="checkbox"/> Take supplements/vitamins
<input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> <input type="checkbox"/> Knocked out / Concussion	<input type="checkbox"/> <input type="checkbox"/> Heat related problems
<input type="checkbox"/> <input type="checkbox"/> Single Testicle	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Recent Mononucleosi
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Enlarged Spleen
<input type="checkbox"/> <input type="checkbox"/> Dizzy / Fainting	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Trait/Anemia
<input type="checkbox"/> <input type="checkbox"/> Organ Loss (kidney, spleen, etc)	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Overnight in hospital
<input type="checkbox"/> <input type="checkbox"/> Surgery	<input type="checkbox"/> <input type="checkbox"/> Prescribed EPI PEN	<input type="checkbox"/> <input type="checkbox"/> Allergies (Food, Drugs) _____
<input type="checkbox"/> <input type="checkbox"/> 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

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 _____
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GENERAL MEDICAL EXAM :

	Norm	Abnl
ENT	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>

ORTHOPAEDIC EXAM :

I. Spine / Neck

	Norm	Abnl
Cervical	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>

II. Upper Extremity

	Norm	Abnl
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>
Hand / Fingers	<input type="checkbox"/>	<input type="checkbox"/>
Wrist	<input type="checkbox"/>	<input type="checkbox"/>

III. Lower Extremity

	Norm	Abn
Knee	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>
Ankle	<input type="checkbox"/>	<input type="checkbox"/>

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

Louisiana High School Athletic Association

Athletic Participation/Parental Permission Form

This form must be completed and signed by the student-athlete's parent prior to a student's participation in an athletic contest and shall be kept on file with the school. It shall remain in effect for the remainder of the student's eligibility unless the student transfers to another member school. This form is subject to review/inspection by the LHSAA or its representative.

PART I: STUDENT INFORMATION (Please Print)

Student's Name: (Last, First, Middle) _____ School Year: _____

Date of Birth: _____ Last Four Digits of SSN: _____

Home Address: _____

City: _____ Zip: _____

My child entered ninth grade in _____ (month and year). Last semester/year he/she attended _____ High School.

ARE YOU ELIGIBLE?

A student athlete in an LHSAA school must meet the following rules to be eligible for interscholastic athletic competition:

<u>RULE</u>	<u>COMMENTS</u>
BONA FIDE STUDENT	A student shall be enrolled in and attending an LHSAA member school on a regular basis and taking the required number of subjects which shall be recorded on the student's official transcript unless student is a special education student or in the 8 th grade or below. A student shall must be counted as a student on the daily attendance records of the school he/she attends. Attendance in one class makes you a student at that school.
ENROLLMENT	A student shall be enrolled and attending a school in the first 11 school days of the school semester at any school or will be ineligible for the first 30 school days.
AGE	A student shall not become 19 years of age prior to August 1 of this year.
PROOF OF AGE	A student shall provide legal proof of age, which meets the provisions of the LHSAA handbook, to the school administrator to be kept on file at school.
CONSECUTIVE SEMESTERS	Once a student shall enter the ninth grade, he/she shall have eight consecutive semesters to play athletics. (EXCEPTION: Hold-Back Repeat Student – See Rule 1.26.6 of the LHSAA handbook)
SCHOLASTIC	For regular education high school students at the end of the first semester a student shall pass at least six subjects in all subjects taken. At the end of the year and prior to the next school year, a student shall must have earned at least six units with an overall "C" average for the entire previous school year as determined by the LEA in all units taken. All seniors must take at least four (4) subjects each semester. Special education students must consult the school principal, athletic director, or coach for scholastic information.
RESIDENCE AND SCHOOL TRANSFERS	Upon entering high school for the first time, a student shall have the choice to attend any member school located in the attendance zone in which the student resides with his/her parent(s)/guardian(s) or any other household with whom the student has been residing for the past calendar year and be immediately eligible unless an applicable exception applies. A transfer to another member school in the same attendance zone shall render the student ineligible for one calendar year.
UNDUE INFLUENCE	If a student shall has been recruited to a school for athletic purposes, he/she shall remain ineligible as long as the student attends that school.
AMATEUR	A student cannot play high school athletics if he/she loses their amateur status.
INDEPENDENT TEAM	In certain sports a student cannot play on a school team and an independent team during the same sport season.

MEDICAL EXAMINATION

A student shall annually pass a physical examination given by a licensed physician/ nurse practitioner that is in collaboration with a licensed physician or a licensed physician's assistant under the supervision of a licensed physician and complete an LHSAA Medical History Evaluation form prior to participating.

ATHLETIC PARTICIPATION/

A school shall only be required to have this form completed and signed prior to the first time

PARENTAL PERMISSION FORM

a student participates in LHSAA athletics at the school unless the student transfers to another member school.

SUBSTANCE ABUSE/MISUSE CONTRACT & CONSENT FORM

A school shall only be required to have this form completed and signed prior to the first time a student participates in LHSAA athletics at the school.

SUSPENDED AND

INELIGIBLE STUDENTS

Shall not participate in any interscholastic contest on any team at any school at any level.

LHSAA ELIGIBILITY RULES APPLY TO STUDENT-ATHLETES ON ALL TEAMS AT ALL LEVELS OF PLAY AT ALL LHSAA SCHOOLS

Eligibility to participate in interscholastic athletics is a privilege a student earns by meeting standards outlined on this form and other regulations and policies set by the LHSAA and the student's school. If you have questions or do not fully understand an eligibility rule, check with your child's principal, athletic director or coach. By following the intent and spirit of the rules, you can help prevent violations which may penalize the student, his/her team and/or his/her school.

ONE INELIGIBLE STUDENT MAY DISQUALIFY YOUR WHOLE TEAM – KNOW THE ELIGIBILITY RULES

PART II – PARENTAL PERMISSION

I have read and reviewed the general requirements for high school athletic eligibility on this form and have discussed these requirements with my child. I understand additional questions/explanations and specific circumstances should be directed to my child's principal, athletic director or coach.

I certify the home address listed on this form is my sole bona fide residence and that I will notify the school principal immediately of any change in my residence, since such a move may alter the eligibility status of my child. All other information given is also accurate and current.

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. Additionally, I give the LHSAA or it representative(s) permission to review my child's scholastic records and all required eligibility forms however submitted by the school or myself.

If the medical status of my child changes in any significant manner after he/she passes his/her physical examination, I will notify his/her principal of the change immediately.

I hereby give my consent and approval for my child to participate in any of the following LHSAA sports:

- | | | |
|---------------|--------------|-----------------|
| BASEBALL | GOLF | SWIMMING |
| BASKETBALL | GYMNASTICS | TENNIS |
| BOWLING | POWERLIFTING | TRACK AND FIELD |
| CROSS COUNTRY | SOCCER | VOLLEYBALL |
| FOOTBALL | SOFTBALL | WRESTLING |

I certify all the information is correct, that I have read the summary of LHSAA eligibility rules below and I am in compliance with these standards. I also acknowledge that my child, by my signature below, has my permission to participate in interscholastic athletics during his attendance at this school. I also understand that this form shall only be completed prior to my child's first participation in any athletic contest of any sport and shall remain in effect for his/her entire athletic eligibility unless he/she transfers to another member school.

By signing below, I agree that my child and I will support and comply with all rules, policies and procedures of the LHSAA as set forth in its Handbook, including its Constitution and Bylaws.

Date: _____ **Parent's Signature:** _____

Relationship to Student _____ **(Print Name)** _____

(Principal Signature) _____




LHSAA SUBSTANCE ABUSE/MISUSE CONTRACT AND CONSENT FORM

This form must be completed and signed and kept on file with the school and is subject to inspection by the LHSAA Rules Compliance Team.

As an LHSAA athlete, I, _____, agree to avoid the abuse or misuse of legal or illegal substances, including anabolic steroids and other performance enhancing drugs. I hereby grant permission to be tested for substance abuse/misuse as a participant in any LHSAA sports program. I furthermore agree to cooperate by providing a urine or hair specimen for testing upon the request of my principal. I understand that should my specimen indicate the abuse or misuse of legal or illegal substances, I will be subject to action specified in my School Drug Policy for Student Athletes.

I, _____, parent/guardian of the undersigned student athlete, individually, and on behalf of my child, do hereby grant permission for and consent to said child being tested for substance abuse/misuse in accordance with his/her School Drug Policy for Student Athletes and I understand that if any specimen taken from him/her indicates abuse or misuse of legal or illegal substances, including anabolic steroids and other performance enhancing drugs, he/she will be subject to action specified in the School Drug Policy for Student Athletes for his/her school.

Dated: _____

Student Athlete

Dated: _____

Parent/Guardian

Dated: _____

Principal

Dated: _____

Head Coach or AD

1.10 ABUSE AND/OR MISUSE OF ILLEGAL SUBSTANCES - Each member school shall develop and implement a substance abuse/misuse policy including procedures for chemical testing of student-athletes. To be eligible for interscholastic athletics, prior to practicing or participating in a sport at an LHSAA school, a student-athlete and his/her parent(s)/guardian shall sign the LHSAA Substance Abuse/Misuse Contract developed and distributed to all schools by the LHSAA. Once signed, the LHSAA Substance Abuse/Misuse Contract shall remain in effect for the remainder of the student-athlete's eligibility. Schools may also have the student and parent/guardian sign a school issued form in addition to the LHSAA Substance Abuse/Misuse Contract. Schools shall be required to keep the signed form on file at the school.

1.10.1 The penalties for failure to have the required LHSAA Substance Abuse/Misuse Contract(s) for all students completed, properly signed, and maintained in the school files shall be:

1. A school shall be fined \$50 per student, per sport for each LHSAA Substance Abuse/Misuse Form not completed, properly signed, and on file with the school not to exceed \$500 per sport.
2. A student in violation of this rule shall not be ruled ineligible for this infraction, but shall be withheld from further team practices and interscholastic athletic participation until a copy of this form is completed and submitted to the Executive Director. The completed form must be faxed or postmarked prior to the athlete's participation

Signature of the LHSAA's contract does not necessarily mean the student athlete will be tested.



Children's Hospital
New Orleans
LCMC Health

ATHLETE INFORMATION CARD

FULL LEGAL NAME: _____ **NICKNAME:** _____

DOB (MM/DD/YYYY): _____ **Sex:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PH #:(_____) _____ **CELL PH #:(_____) _____** **GRADE:** _____

SPORT/SPORTS PLAYED: _____ **HT:** _____ **WT:** _____

EMERGENCY CONTACT INFO

EMERGENCY CONTACT #1:

RELATIONSHIP: MOM _____ DAD _____ OTHER (_____)

FULL NAME: _____ **DOB:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PH #:(_____) _____ **CELL PH #:(_____) _____** **WORK PH #:(_____) _____**

EMERGENCY CONTACT #2:

RELATIONSHIP: MOM _____ DAD _____ OTHER (_____)

FULL NAME: _____ **DOB:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PH #:(_____) _____ **CELL PH #:(_____) _____** **WORK PH #:(_____) _____**

HEALTH INSURANCE NAME: _____ **PH #:(_____) _____**

NAME OF INSURED: _____

I hereby release the above listed information to the Children's Hospital New Orleans (CHNOLA) sports medicine team. I agree to allow this information to be shared when medically necessary to allow for approved/necessary care.

Parent/Guardian Name

Parent/Guardian Signature

Date



Children's Hospital
New Orleans
LCMC Health

Consent to Treatment and Release of Liability Form

I, parent/guardian, of student-athlete understand that Children's Hospital (CHNOLA) contracts with the student-athlete's school to provide athletic training services as outlined by the National Athletic Trainers' Association (NATA) and the Louisiana State Board of Medical Examiners (LSBME). I give permission to CHNOLA Sports Medicine personnel to assess, treat, rehabilitate, and, when indicated, recommend referral to an appropriate medical provider to treat the student-athlete's injury or condition.

I agree to allow the CHNOLA Sports Medicine personnel to utilize modalities, rehabilitation techniques, and any other treatment as outlined in the CHNOLA Sports Medicine Standing Orders. In the event of an emergency, I understand that CHNOLA Sports Medicine personnel will contact Emergency Medical Services (EMS) when advanced medical care and emergent medical transportation is needed.

I authorize CHNOLA Sports Medicine personnel to administer and utilize a baseline and post-injury neurocognitive concussion testing program through IMPACT Applications. CHNOLA Sports Medicine personnel will share this information with medical providers directly involved in the student-athlete's care during the process of return to learn and return to play following a head injury. Information regarding this testing program can be found at www.impactconcussion.com.

Acceptance of Risk and Release of Liability

I understand the inherent risks involved with the participation in athletic events which can lead to minor and major injuries. I understand that neither the protective equipment and padding used in sport, the safety rules and procedures of the sport, the coaching instruction received, nor the athletic training care provided to student-athletes will guarantee safety or prevent injuries that may be sustained as a result of participation in athletic events. I agree not to hold CHNOLA Sports Medicine personnel responsible for any injury, loss, or damage that occurs to the student-athlete as a result of athletic participation.

Statement of Permission

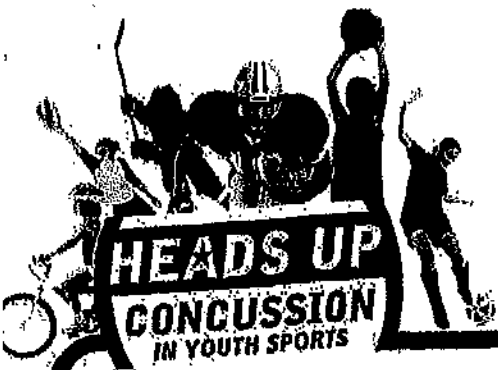
I have read and fully understand this consent to treat and release of liability. I voluntarily sign this without inducement. I give permission to CHNOLA Sports Medicine and all associated with CHNOLA to assess, treat, and rehabilitate the student-athlete as needed. I understand that this consent and waiver to liability will be in effect as long as the student-athlete is enrolled in the associated school. However, I understand that I may withdraw my consent from such care at any time without affecting my right to future care or treatment. I may revoke my consent in writing at any time by contacting CHNOLA Sports Medicine personnel.

Print Student-Athlete Name

Print Parent/Guardian Name

Parent/Guardian Signature

Date



HEADS UP CONCUSSION IN YOUTH SPORTS

A Fact Sheet for PARENTS

WHAT IS A CONCUSSION?

A concussion is a brain injury. Concussions are caused by a bump or blow to the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

Signs Observed by Parents or Guardians

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

Symptoms Reported by Athlete

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Does not "feel right"

HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION?

Every sport is different, but there are steps your children can take to protect themselves from concussion.

- Ensure that they follow their coach's rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity (such as helmets, padding, shin guards, and eye and mouth guards). Protective equipment should fit properly, be well maintained, and be worn consistently and correctly.
- Learn the signs and symptoms of a concussion.

WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

1. **Seek medical attention right away.** A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to sports.
2. **Keep your child out of play.** Concussions take time to heal. Don't let your child return to play until a health care professional says it's OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a second concussion. Second or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.
3. **Tell your child's coach about any recent concussion.** Coaches should know if your child had a recent concussion in ANY sport. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

It's better to miss one game than the whole season.

**Louisiana High School Athletic Association
Parent and Student-Athlete Concussion Statement**

I understand that it is my responsibility to report all injuries and illnesses to my coach, athletic trainer and/or team physician.

I have read and understand the Concussion Fact Sheet.

After reading the Concussion Fact Sheet, I am aware of the following information:

Parent Initial

Student Initial

_____ _____ A concussion is a brain injury, which I am responsible for reporting to my coach, athletic trainer, or team physician.

_____ _____ A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance

_____ _____ You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

_____ _____ If I suspect a teammate has a concussion, I am responsible for reporting the injury to my coach, athletic trainer, or team physician.

_____ _____ I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.

_____ _____ Following concussion the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.

_____ _____ In rare cases, repeat concussions can cause permanent brain damage, and even death.

Signature of Student-Athlete

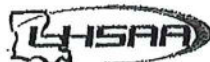
Date

Printed name of Student-Athlete

Signature of Parent/Guardian

Date

Printed name of Parent/Guardian





De La Salle Sports Medicine Team



Certified Athletic Trainer

Jelessa Penn, M.S. Ed, LAT, ATC
Children's Hospital New Orleans

jelessa.penn@lcmchealth.org or jpenn@delasallenola.com

Jelessa oversees all sporting events and athletically related injuries. We encourage our athletes to see our school athletic trainer and or team doctor to determine the level of severity of the injury. Jelessa will help set up all appointment to provide care to our student athletes.

Team Physician



Dr. Joseph L. Finstein, MD

Board Certified Orthopedic Surgeon

Metairie Office: 3939 Houma Blvd. Suite 21

Metairie, La 70006

504-885-6464

Children's Hospital of New Orleans

200 Henry Clay Avenue

New Orleans, La 70118

504-899-9511



Children's Hospital
New Orleans
LCMC Health

**CRANE REHAB CENTER
PHYSICAL THERAPY**

Team Physical Therapist

Morell (Mo) Crane, PT

River Road Office

101 River Road #112

Jefferson, La 70121

504-828-7696

All appointments will be scheduled through the student athlete after seeing the athletic trainer and/or the team physician.

Questions: athletics@delasallenola.com.