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.

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

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

*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.**

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:

RULE	COMMENTS
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 8th 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/ PARENTAL PERMISSION 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 **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 ELIGIBLITY 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) Richard Mach

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.

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

LHSAA

Manning Family
Children's
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 Manning Family Children's 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

Manning Family
Children's
LCMC Health

Consent to Treatment and Release of Liability Form

I, parent/guardian, of student-athlete understand that Manning Family Children's 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 Manning Family Children's 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 Manning Family Children's Sports Medicine personnel to utilize modalities, rehabilitation techniques, and any other treatment as outlined in the Manning Family Children's Sports Medicine Standing Orders. In the event of an emergency, I understand that the Manning Family Children's Sports Medicine personnel will contact Emergency Medical Services (EMS) when advanced medical care and emergent medical transportation is needed.

I authorize Manning Family Children's Sports Medicine personnel to administer and utilize a baseline and post-injury neurocognitive concussion testing program through IMPACT Applications. Manning Family Children's 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 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 Manning Family Children's 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 Manning Family Children's Sports Medicine and all associated with Manning Family's Children's 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 Manning Family Children's Sports Medicine personnel.

_____
Print Student-Athlete Name

_____
Print Parent/Guardian Name

_____ _____
Parent/Guardian Signature **Date**

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

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.