

MEDICAL HISTORY EVALUATION

IMPORTANT: This form must be completed annually, kept on file with the school

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)

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 examination 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.
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.
3. I give my permission to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school.

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 :

Table with columns: Norm, Abnl. Rows: 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

Table with columns: Norm, Abnl. Rows: 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