## *BROTHER MARTIN MEDICAL SUPPORT*

# ATHLETE MEDICAL INFORMATION CARD

***TO THE PARENT***: This card will be used solely as an aid to providing your son the necessary health care while he attends Brother Martin High School. THIS INFORMATION IS CONFIDENTIAL. **No Copies, faxes, or other physical forms will be accepted.**

***PLEASE TYPE OR PRINT BOLDLY IN BLACK INK ONLY. ALL LINES MUST BE COMPLETED.***

STUDENT # _____ SS# _____ SPORT(S) _____

NAME _____ DOB _____ GRADE_____

ADDRESS _____ CITY _____ ZIP_____

HOME PHONE # _____ (OTHER) _____

NAME OF PARENT/GUARDIAN _____

ADDRESS _____ CITY _____ ZIP _____

MOTHER: (H) _____ (W) _____ (OTHER) _____

FATHER: (H) _____ (W) _____ (OTHER) _____

**PERSON OTHER THAN PARENT/GUARDIAN TO CONTACT IN CASE OF EMERGENCY:**

NAME_____ RELATION _____

ADDRESS _____ CITY _____ ZIP_____

PHONE: (H) _____ (W) _____ (OTHER) _____

**FAMILY PHYSICIAN INFORMATION:**

NAME _____ SPECIALTY _____

ADDRESS _____ CITY _____ ZIP _____

PHONE: (OFFICE) _____ (EMERGENCY) _____

**INSURANCE COMPANY INFORMATION: IS YOUR INSURANCE AN HMO?** ☐ YES ☐ NO **PPO?** ☐ YES ☐ NO

PRIMARY _____ POLICY # _____

DOCTOR _____ HOSPITAL _____

## PARENT PERMISSION FOR STUDENT ATHLETE PARTICIPATION

The school's athletic program is an integral part of the curriculum, and school personnel have devoted great effort to assure that participating students are protected in every way possible. However, participation in athletics includes risk of injury which may range in severity from minor to long-term catastrophic, including paralysis and death.

Participants have the responsibility to help reduce the chance of injury. Participants must obey all safety rules and regulations, report all physical problems to the coach and athletic trainer, follow a proper conditioning program, and inspect personal protective equipment daily. Proper execution of skill techniques must be followed for every sport, and especially in contact sports, the head is not ever to be used as a "ram," and the head should not be used as an initial contact point.

**PLEASE INITIAL EACH OF THE FOLLOWING STATEMENTS TO SHOW THAT THE STATEMENT HAS BEEN READ, UNDERSTOOD, AND APPROVED.**

_____ I/We consent to have my son/ward represent his school in approved athletic activities **EXCEPT** those activities excluded by the examining doctor and the activities I list here: _____

_____ I/We grant permission for my son/ward to accompany any school team of which he is a member to out-of-town trips. I/We realize that when transportation is provided by the school, it will be in school approved vehicles. I/We realize that parents/guardians wishing to have their son/ward with them when returning from an event must make written arrangements with the coach.

_____ In the event of an emergency requiring medical attention, I expect every reasonable attempt to be made to contact me. In case I cannot be reached, I grant permission for any immediate treatment deemed necessary by the attending physician and transfer of my son to a qualified medical facility. This authorization does not cover major surgery unless formally decreed prior to surgery by two licensed physicians or dentists.

_____ I/We recognize and acknowledge that there are risks in my son's/ward's presence and participation in the school sponsored program. I agree to indemnify, hold harmless, waive and relinquish all claims I may have against Brother Martin High School including any negligence claims on their part and its officers, agents, employees, representatives or volunteers arising out of or in connection with the transportation to and/or from the event or any activity my son/ward participates in while attending the school sponsored program.

_____ I acknowledge and accept that there are risks of physical injury involved in athletic participation which may result in permanent paralysis, mental disability, and death.

_____By my signature, I acknowledge these facts and understand that my son/ward is representing Brother Martin High School while participating in this activity and will, therefore, conduct himself in a manner consistent with the philosophy and objectives of Brother Martin High School Behavior Policy and Training Room policies at all times.

_____I have completed my son's/ward's current Medical Insurance information in the Insurance Company Information section above.

_____ _____/_____/_____ _____

Parent/Legal Guardian Date Parent/Legal Guardian

# 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 one year on the last day of the month that it was signed and dated by the MD, DO, APRN or PA.**

*Revised 5/14*