



EAST BATON ROUGE PARISH SCHOOL SYSTEM

ATHLETE'S NAME: _____ Date: _____

SEX: Male or Female AGE: _____ D.O.B. ___/___/___ Grade: _____
(Circle One)

PARENTAL CONSENT FORM FOR ATHLETICS - 2021-2022

I have been informed that my son/daughter desires to participate in athletics this year, and he/she has my consent to do so. In signing this form, I understand that he/she will participate in sport activities where there is the possibility of injury, ranging from minor to severe. I also understand that he/she must meet certain eligibility requirements set by the Junior Recreation Athletic Association and the North Baton Rouge Parish School Board. I am also willing to abide by those rules as administered through the athletic association and the school staff.

I hereby give my consent for the above-named student to represent _____ Middle School in his/her sport and for him/her to accompany the team on athletic trips. This may include games, practices and scrimmages.

I understand my child must submit to their coach a LHSAA Medical History (Physical) Form (dated July 1, 2021 to present for the 2021-2022 school year). A copy of the physical exam will be good for all sports during the 2021-2022 year and will be kept on file in the designated location. THE MEDICAL EXAM MUST BE ADMINISTERED AND SIGNED BY A MEDICAL DOCTOR OR LICENSED NURSE PRACTITIONER BEFORE MY CHILD IS ALLOWED TO PRACTICE OR COMPETE.

The student must have health insurance before being eligible to participate in middle school athletics. A copy of the student's insurance card must be given to the coach and placed in my child's folder.

The school system offers (for purchase) the voluntary student accident insurance that will cover your child for athletics in case of an injury. A Declaration Declining Student Accident Insurance Form must be signed if you do not wish to purchase this voluntary student accident insurance. Go to www.studentinsurance-kk.com; under parents, click Purchase Coverage; type in East Baton Rouge and enter LA; click View Insurance Products/Purchase Coverage; click Buy Online Now with a Debit or Credit Card or Print and Pay by Check.

Parent/Legal Guardian's Signature: _____

DECLARATION DECLINING STUDENT ACCIDENT INSURANCE - 2021-2022

In accordance with the East Baton Rouge Parish School Board Policy JGA and La. Rev. Stat. Ann.

§17:81, I _____, the parent of _____
(Parent/Guardian) (Child's Name)

hereby decline the voluntary student insurance made available for purchase through the East Baton Rouge Parish School Board.

I also hereby acknowledge that if my child is participating in any middle school interscholastic athletic program, he or she, in accordance with the East Baton Rouge Parish School Board's policy, CANNOT participate without insurance.

Additionally, whether my child is participating in any high school or middle school interscholastic athletic program, I hereby acknowledge full responsibility for any expenses associated with any injury suffered by my child as a result of participating in any interscholastic athletic program in the East Baton Rouge Parish School System.

Parent/Legal Guardian's Signature: _____

PARTICIPATION WITH AN INDEPENDENT TEAM/ORGANIZED GROUP - 2021-2022

A student shall not be permitted to take part in any branch of athletics not sponsored by the school while he/she is a member of a school team or squad in that same sport. This includes playing or participating with an organized group.

The penalty for violating this rule if it occurs while the student is practicing with an independent team or organized exhibition group, shall be suspension in the sport for the remainder of the school year should said student participate in an athletic contest with the school team after having committed the violation. The penalty for violation of this rule if it occurs while playing with an independent team or organized group will be suspension of one (1) calendar year in that same sport should said student participate in an athletic contest with the school team in that same sport after having committed the violation.

Parent/Legal Guardian's Signature: _____

PARENTAL/LEGAL GUARDIAN MEDIA CONSENT FORM - 2021-2022

I hereby consent to the use of any photographs/video tape taken of my child by the East Baton Rouge Parish School System or the media for the purpose of advertising or publicizing events, activities, facilities and programs of the East Baton Rouge Parish School System in newspapers, newsletters, website, other publications, television, radio and other communications and advertising media.

By law, the East Baton Rouge Parish School System protects the privacy of the students and is prohibited from releasing students' personal information.

From time to time representatives of the news media are invited to campus to cover events at our schools. When this happens there is a possibility your child/children may be photographed, videotaped, or interviewed for a news story.

Please mark one of the choices below and return to school.

_____ Yes, I allow my child/children to be identified in any good news district or school publication.

_____ No, I do not want my child/children identified in any good news district or school publication.

Parent/Legal Guardian's Signature: _____

I have read the and understand the above statements and regulations, and _____ has my
(Student's Name)
permission to take part in athletics at _____ Middle School this 2021-2022 school year.

Student's Name: _____ Please Print Student's Signature: _____

Parent's Name: _____ Please Print Parent's signature: _____ Date: _____

APPROVED: _____
Principal's Signature

Concussion: Statement of Student-Athlete Responsibility and Parent Awareness - Louisiana Youth Concussion Act 314

What is a Concussion?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

Facts about Concussions

1. A concussion is a serious brain injury
2. Concussions can occur without a loss of consciousness or other obvious signs
3. Concussions can occur from blows to the body as well as to the head
4. Concussions can occur in any sport
5. Athletes can still get a concussion even if they are wearing a helmet
6. Recognition and proper response to concussions when they first occur can help prevent further injury or even death.

Symptoms Reported by Athlete:

Headache or "pressure" in head	Nausea or vomiting
Balance problems or dizziness	Double vision
Sensitivity to light or noise	Confusion
Feeling sluggish, hazy, foggy or groggy	Blurry vision
Just not "feeling right" or is "feeling down"	
Concentration or memory problems	

FOR more information:
cdc.gov/concussion

Signs Observed by Parents, Friends, Teachers, or Coaches

Appears dazed or stunned	Loses Consciousness (even briefly)
Is confused about what to do	Moves clumsily
Forgets plays or instruction	Answers questions slowly
Is unsure of game, score, or opponent	Shows mood, behavior, or personality changes
Can't recall events prior to hit or fall	Can't recall events after hit or fall

Concussion Danger Signs

One pupil larger than the other	Is drowsy or cannot be awakened
A headache that get worse	Weakness, numbness, or decreased coordination
Repeated vomiting or nausea	Slurred speech
Convulsions or seizures	Cannot recognize people or places
Has unusual behavior	Becomes increasingly confused, restless, or agitated
Loses consciousness (even a brief loss of consciousness should be taken seriously)	

Signs and symptoms of a concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If an athlete reports one or more symptoms of a concussion listed above after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care professional. Experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

Statement of Student Athlete Responsibility

I accept responsibility for reporting all injuries and illnesses to the coach and parent(s) including any signs and symptoms of a Concussion. I have read and understand the above information on concussions.

Student Printed Name _____ Student's Signature _____

As a parent of the above-mentioned student, I am also aware of the issues concerning concussions as mentioned in this document and agree to adhere to these guidelines.

Parent's Signature _____ Date _____



1. Activities and Approximate Dates: (To be completed by the School)

For the (School Name) Girls/Boys Athletic Events Team to attend middle school Sports Contests from August 2021 to May 15, 2022.

2. I do hereby grant permission for the following student to attend and participate in the described activities.

<u>Student Name (Please Print)</u> _____	<u>Student ID Number</u> _____	<u>School Name</u> _____	
<u>Parent or Legal Guardian Name</u> (Please Print) _____	<u>Legal Relationship</u> () Parent () Foster Parent () Legal Guardian	<u>Signature</u> _____	<u>Date</u> _____

3. AUTHORIZATION TO PROVIDE MEDICAL TREATMENT

In the event of any injury sustained in the course of the above activity, school system representatives are authorized to render necessary medical treatment to the student listed above.

Signature of Parent or Legal Guardian: _____

4. RELEASE OF MEDICAL RECORDS AND REPORTS

You or any physician, hospital, clinic or medical care provider are authorized to furnish to the North Baton Rouge Parish School Board, all medical records, information, facts, and particulars which may be requested and to furnish them copies of such.

This information is to be used for the purposes of evaluating and handling this student's claim of injury as a result of the accident on the date indicated in Section 5. A photocopy of this form may be accepted with the same authority as the original.

Signature of Parent or Legal Guardian: _____

5. TO BE COMPLETED BY PHYSICIAN ONLY IN THE EVENT OF INJURY

Date of Injury _____ Initial Diagnosis _____

Signature of Physician or Authorized Representative _____

Date _____

Name, Address, and Phone Number of Medical Facility _____

Date _____

LHSAA MEDICAL HISTORY EVALUATION

IMPORTANT: This form must be completed each academic year. 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
<input type="checkbox"/> <input type="checkbox"/> Heart Attack/Disease	_____	<input type="checkbox"/> <input type="checkbox"/> Sudden Death	_____
<input type="checkbox"/> <input type="checkbox"/> Stroke	_____	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> <input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Trait/Anemia	_____
		<input type="checkbox"/> <input type="checkbox"/> Arthritis	_____
		<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	_____
		<input type="checkbox"/> <input type="checkbox"/> Epilepsy	_____

ATHLETE'S ORTHOPAEDIC HISTORY: Has the athlete had any of the following injuries?

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"/> Elbow L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Arm / Wrist / Hand L / R	_____
<input type="checkbox"/> <input type="checkbox"/> Hip L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Thigh 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"/> Foot L / R	_____	<input type="checkbox"/> <input type="checkbox"/> Severe Muscle Strain	_____
<input type="checkbox"/> <input type="checkbox"/> Chest	_____	<input type="checkbox"/> <input type="checkbox"/> Pinched Nerve	_____

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"/> Asthmas / 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 Mononucleosis
<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)..... Yes No

Date Signed by Parent _____ Signature of Parent _____ Typed or Printed Name of Parent _____

II. COMPLETED ANNUALLY BY MEDICAL DOCTOR (MD), OSTEOPATHIC DOCTOR (DO), NURSE PRACTITIONER (APRN) or PHYSICIAN'S ASSISTANT (PA)

Height _____ Weight _____ Blood Pressure _____ Pulse _____

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"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
(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	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>
II. Upper Extremity		
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>
Wrist	<input type="checkbox"/>	<input type="checkbox"/>
Hand / Fingers	<input type="checkbox"/>	<input type="checkbox"/>
III. Lower Extremity		
Hip	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>
Ankle	<input type="checkbox"/>	<input type="checkbox"/>

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 is good from July 1, 2021 to June 30, 2022 and must be signed by the MD, DO, APRN, or PA.

Revised 5/18