

LHSAA MEDICAL HISTORY EVALUATION

IMPORTANT: This form must be completed annually, kept on file with the school, and is subject by the LHSAA Rules Compliance Team.

PART I: INFORMATION (To be filled out by parent or guardian only)

Name: _____ Grade: _____ School: _____
Sex: M / F Age: _____ Date of Birth: _____ Home Telephone #: _____ Sports: _____
Address: _____ City: _____ Zip: _____
Parent's Name: _____ Parent's Employee: _____ Work Telephone#: _____
Insurance Company _____ Policy# _____ Family Doctor _____

PART II MEDICAL HISTORY (To be filled out by parent or guardian)

Has or Does this athlete _____ Circle & Please explain all "yes" answers below

1. Have a medical problem or injury since his/her last evaluation?..... YES NO
Ever not been allowed to participate in sports for medical reason?..... YES NO
2. Ever been hospitalized? YES NO
Every had surgery? YES NO
Have any missing organs (*eye, kidney, testicles, etc.*) YES NO
3. Presently take any medications..... YES NO
4. Have any allergies to medicine or insect bites? YES NO
5. Passed out during or after exercise? YES NO
Been dizzy or passed out during or after exercise?..... YES NO
Have chest pains during or after exercise? YES NO
Tire more quickly than his/her friends during exercise?..... YES NO
Have high blood pressure YES NO
Been told he/she has a heart murmur? YES NO
Have racing of the heart or skipped heart beats? YES NO
Have family members that died of heart problems or sudden death before age 50? YES NO
6. Ever had skin problems?..... YES NO
7. Ever had a head or neck injury? YES NO
Ever been knocked out or unconscious?..... YES NO
Ever had a seizure? YES NO
Ever had a stinger, burner or pinched nerve? YES NO
8. Ever had heat cramps? YES NO
Ever been dizzy or passed out in the heat? YES NO
9. Have trouble with breathing or coughing during or after activity? YES NO
10. Use any special equipment? (*pads, braces, neck rolls, eye guards, kidney belt, etc.*) YES NO
11. Have any problems with vision?..... YES NO
Wear glasses or contacts? YES NO
12. Ever sprained/strained, dislocated, fractured or had repeated swelling of any bones or joints? YES NO
13. Have any medical problems listed below? (Please check off)
___ High Blood Pressure ___ Rheumatic Fever ___ Diabetes ___ Hepatitis
___ Mononucleosis ___ Abnormal Bleeding ___ Tuberculosis ___ Asthma
___ Sickle Cells Disease/Trait ___ Other (list) _____
14. List dates for last: Tetanus Shot: _____ Measles Immunization: _____
15. Female athletes, list dates for: First Menstrual Period _____ Last Menstrual period _____
Longest Time between periods last year: _____
Please explain all "yes" answers from above: _____

PART III: SIGNATURES

(You must answer these questions and sign for your child to be examined)

1. The information on the reverse is current and correct to the best of my knowledge.....YES NO
2. I give my permission for my child to be examined for school-related activities.....YES NO
3. 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 necessaryYES NO
4. I recognize the evaluation to be done on my child is a standard pre-participation screening examination and that no in-depth testing, x-rays, lab work, or cardiac testing will be performed.....YES NO
5. 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 immediatelyYES NO
6. 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

Signature of Parent/Guardian: _____ Date: _____

Signature of Student Athlete: _____ Date: _____

PART IV PHYSICAL *(To be filled out annually by a licensed physician/licensed nurse practitioner in collaboration with doctor or a licensed physician's assistant under the supervision of a licensed physician.)*

L I M I T E D	Height	Weight		Blood Pressure	/	Pulse
	SYSTEM	NORMAL	ABNORMAL	INITIALS		COMMENTS
C O M P L E T E	Heart					
	Lung					
	Other					
	Abdominal					
	Genitalia					
	Neck					
	Shoulder					
	Elbow					
	Wrist					
	Hand					
	Back					
	Knee					
	Ankle					
	Foot					
Eye	Right 20/	Left 20/	Corrected?	YES / NO		

CLEARANCE: _____ **A. Cleared**
 _____ **B. Cleared after further evaluation/treatment**
 _____ **C. Not cleared for:** _____ **Collision** _____ **Contact** _____ **Non-contact**

RECOMMENDATIONS: _____

NAME OF MD/NURSE PRACTITIONER _____ **DATE** _____

ADDRESS: _____ **TELEPHONE:** _____

SIGNATURE OF MD/NURSE PRACTITIONER: _____