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Athletics

Scott Stevens, Principal
Elmo Fernandez, Athletic Director

Returning Athletes

Need To Complete The Following:

Athlete's Name_____

- **LHSAA Medical History Evaluation**
- **Woodlawn High Informed Consent/Emergency Treatment Release**
- **LHSAA Concussion Parent / Athlete Statement**
- **Woodlawn Parent / Athlete Concussion Information**
- **Copy of Insurance Card – Front & Back**

Please make sure all forms are completed and all signatures have been provided

All forms must be completed in their entirety before athlete will be able to participate

Date Completed Packet Returned:_____

Date of Physical:_____

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 13 months from the date it was signed and dated by the MD, DO, APRN or PA.

Revised 6/18

Student's Name:_____

Woodlawn High Athletics

Informed Consent / Emergency Treatment Release / Hold Harmless / Insurance Declaration

I have been informed that my son / daughter wishes to participate in an interscholastic sport while attending Woodlawn High School. In signing this form, I understand that any sport he / she participates is a high risk sport and I am aware that there is a possibility of injury, ranging from minor to severe and life threatening. I also understand that he / she must meet certain eligibility requirements prescribed by the Louisiana High School Athletic Association, East Baton Rouge Parish Schools, and Woodlawn High School. I am willing to abide by those rules, as administered through the Louisiana High School Athletic Association and Woodlawn High School Administration and Athletic Staff.

In the event that my son / daughter is injured during strength or conditioning, practice or athletic competition:

- Permission is given to the certified athletic trainer and / or coaching staff to provide basic and emergency care until such time that a parent or guardian is notified
- Permission is given to the certified athletic trainer to provide continued care and treatment of athletic injuries under the supervision of our team physician.
- Should a medical emergency arise, and parents can't be notified permission is given to the certified athletic trainer and / or coaching staff to seek emergency treatment and be transferred to the hospital of the parent's preference or nearest hospital for emergency treatment. Permission is also granted to the medical facility and any attending physician to provide medical treatment and perform any diagnostic imaging or testing as the attending physician deems necessary.

The East Baton Rouge School Board and its members, employees, agents, assigns and insurers shall be held harmless from and against any liability for any accidents involving the student while participating in such athletic activities and any injuries suffered by the student during, or as a result of, such participation. Woodlawn High School nor the East Baton Rouge Parish School Board shall be held responsible for any medical or emergency transportation bills that may be incurred while participating in an athletic practice, competition or event. I understand that as the parent or guardian that I am responsible for all medical bills that may be incurred while participating in strength and conditioning, practice, competition or any other event associated with the participation in a school sponsored interscholastic sport.

Per East Baton Rouge Parish School Board Policy, no student athlete shall be allowed to participate in any strength and conditioning, practice, or interscholastic athletic event without providing prior proof of insurance or the purchase of an insurance policy offered through East Baton Rouge Parish Schools. Parents shall provide proof of insurance by providing a copy of the front and back of a current insurance card and must match the information below**. No student will be allowed to participate in strength and conditioning, practice or competition in any way without the proof of insurance.**

☐ **I wish to purchase insurance coverage provided through East Baton Rouge Parish Schools.**

☐ **I decline to purchase insurance coverage provided through East Baton Rouge Parish Schools and will provide proof of private insurance by providing insurance information below and a copy of the front and back of a current insurance card.**

Any and all medical instructions such as hospital preference drug allergies, asthma medication should be listed on the bottom of this form.

_____ _____ _____

Parent's Name Printed **Parent's Signature** **Date Signed**

Mother's Cell Phone: _____ **Insurance Company:** _____

Father's Cell Phone: _____ **Policy Holder:** _____

Alternate Contact Name: _____ **Date of Birth:** _____

Alternate Contact Phone: _____ **Policy Number:** _____

Hospital Preference: _____ **Primary Care Physician:** _____

Drug Allergies or Special Instructions: _____

_____

_____

_____

_____

_____

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

Woodlawn Athletics Parent & Student Concussion Information

Act 314

The Louisiana Legislature in 2011 passed the Louisiana Youth Concussion act. This law requires that all parents, athletes, and coaches be made aware of the following

- **The nature and risk of concussions**
- **The risk associated with continuing to play after a concussion or head injury**
- **Sign a concussion and head injury information sheet which includes the return to the play protocol**

What is a concussion? A concussion is a brain injury that:

★ **Is caused by a bump or blow to the head**
★ **Can change the way your brain normally works**
★ **Can occur during practice or games in any sport**
★ **Can happen even if you haven't been knocked out**
★ **Can be serious even if you've just been "dinged"**

Symptoms that may be felt by the Athlete or seen by an Athletic Trainer, Coach, Teammate, or Parent

Headache or "Pressure" in Head

Nausea or Vomiting

Balance Problems or Dizziness

Double or Blurry Vision

Bothered by Light or Noise

Sluggish, Hazy, Foggy, or Groggy

Difficulty Paying Attention

Memory problems

Confusion

Don't Feel Right

Parent's should look for these Symptoms of Concussion or Head Injury

Appears Dazed or Stunned

Confused About Assignment or Position

Forgets Instructions

Unsure of Game, Score, or Opponent

Moves Clumsily

Answers Questions Slowly

Loses Consciousness (even briefly)

Shows Changes in Behavior and / or Personality

Can't Recall Events Prior to Hit or Fall

Should these Symptoms Appear or Worsen then Seek Further Medical Attention

Worsening Headaches

Vomiting

Decreased Level of Consciousness

Dilated Pupils

Increased Confusion

Stumbling / Loss of Balance

Weakness in One Arm / Leg

Blurred Vision

Increased Irritability

It is okay to	Do Not
Use Tylenol	Use Aspirin, Aleve, Advil or other NSAID products
Ice pack to head / neck for comfort	Drink alcohol
Eat a light meal	Eat spicy foods
Go to sleep	Drive a car

What do I do next?

If the athlete or anyone associated with the athlete detects signs of a concussion then the athlete should be immediately removed from play and referred to a medical doctor or a doctor of Osteopathic Medicine for further evaluation.

- ➔ **When in doubt sit them out**
- ➔ **On-site evaluation by appropriate health-care professional: Physician, Certified Athletic Trainer, EMT and removed from play for the remainder of that day's competition.**
- ➔ **Athlete is medically cleared by a Medical Doctor or Doctor of Osteopathic Medicine**
- ➔ **Step-wise protocol for return to learn and return to play is initiated as determined by a physician**
- ➔ **Upon completion of Return to Play protocol athlete is then released by attending physician.**

Return to Play Protocol

The return to play protocol has been established by a medical doctor. It is a stage progression in which the athlete takes one stage at a time. If at any time the symptoms of a concussion return, the athlete will not progress to the next stage. There is no definite time table for the return to play.

We are fortunate that our athletes will have baseline data available for the doctors to review. The baseline data will include memory function as well as balance. The baseline data will also give physicians objective data in which to make decisions.

Return to Play Protocol Steps

1. **Rest - athlete should sleep: no television, no video games, no text messaging, rest the brain**
2. **Return to Class - athlete returns to academic activities, however, athlete may need modifications in assignments, suggested modifications would be extended time, modified length of assignments.**
3. **Light aerobic activity - athlete participates in aerobic activity either inside or outside.**
4. **Sport Specific Training - athlete participates in drills specific to their sport with a higher intensity than light aerobic activity**
5. **Non-Contact training drills - athlete progresses to sport specific drills but there is no contact. Athlete wears full uniform and increases intensity.**
6. **Full-Contact training drills - athlete after having been medically cleared for full-contact participates in team drills where contact is allowed.**
7. **Return to Competition - athlete is allowed to return to full competition after being re-evaluated by attending physician.**

Additional Resources

Brain 101 - The Concussion Playbook

Heads Up: Concussion in High School Sports