
**Notre Dame High School Athletics**
**910 North Eastern Avenue**
**Crowley, LA 70526**
**337.783.8776**
**337.783.8781 (fax)**
**athletics@ndpios.com**

*Pioneer Parents,*

*The attached forms are all required for students competing in the Notre Dame athletic program. All forms must be signed by parents and students. Please check them carefully before sending them in to the athletic office. Note that the physical form has a blank for a parent/ guardian to sign.*

*Notre Dame also requires that we have proof of insurance coverage for your child. A copy of your insurance card will suffice.*

***All forms must be received before a student is allowed to compete.***

*Athletic fees are also assessed for each student athlete, manager and trainer.* ***The yearly fee is $150.00 for each child*** *and payment is requested at the beginning of the sport. If you have questions, please contact me.*

*Sincerely,*

*Mary Baronet*

*Mary Baronet*
*Athletic Secretary*

# 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*

# Handout: Concussion Preseason Student & Parent Education

**Your school / sport team partners with Concussion Solutions, LLC to provide concussion management services for its student-athletes and parents. Concussion Solutions is the provider of a health management system that establishes the highest standard of care for safe return to activity by coordination communication between the coach, parent, student-athlete, school administration, and local medical experts that utilize industry leading tools in the diagnosis and treatment of -related concussion. Below is information mandated by the Louisiana Youth Concussion Act (RS 40-1299.181) regarding sport-related concussion:**

**What is a concussion?**
A concussion is a brain injury that results in your brain not working as it should. Any blow to the head, face, neck, or body that causes a sudden shaking or jarring of the brain inside the skull may cause a concussion. You do not have to get hit in the head to have a concussion. For example, receiving a hard hit in football or a collision with a wall or the ground that jars the head and neck can cause a concussion. Also, you do not need to lose consciousness to have a concussion. Only a small percentage of concussions result in loss of consciousness.

Concussions are not a structural injury (i.e. a skull fracture), but can better be described as a metabolic dysfunction that leaves the brain in a very vulnerable state and can change the way your brain normally works. This metabolic dysfunction can cause a myriad of symptoms that may not present themselves until hours or even days after the injury and typically presents differently for each student-athlete. Thus, each injury should be managed individually.

**Common symptoms:**
You can't "see" a concussion per say, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury and can sometimes last for weeks or even longer in some cases. Concussion may cause one or multiple symptoms that can interfere with the student-athlete's academic, athletic, and personal or social life. Concussions occur most frequently in football, but women's soccer, men's and women's basketball, volleyball, and wrestling follow closely behind. All student-athletes are at risk. Concussion signs and symptoms include but are not limited to the following:

- **Physical Symptoms:** headache, nausea, vomiting, balance problems, dizziness, light-headedness, "pressure in head" sensation, neck pain, fatigue or low energy, sensitivity to light and/or noise, blurred or abnormal vision, numbness or tingling.
- **Sleep Symptoms:** sleeping less, sleeping more than usual, trouble falling asleep, drowsiness
- **Emotional Symptoms:** irritability, sadness, nervous or anxious, feeling more emotional than normal
- **Cognitive symptoms:** feeling slowed down, feeling like in a fog, difficulty concentrating, difficulty remembering

**How long will symptoms last?**
The length of symptoms varies greatly between individuals. For some, symptoms may last less than 24 hours, while for others symptoms may last several weeks to months. Some concussion symptoms may not appear right away, over the first 48-72 hours these symptoms should evolve and peak. It is important to know that even after the physical symptoms are gone, the brain is still healing. It usually takes at least 1-2 weeks once symptom-free before you are safe to return to full participation. That is why it is important to follow an appropriate Return to Play Protocol supervised by a licensed healthcare professional.

**Can I prevent a concussion?**
Preventing concussion injuries is challenging. The yolk of the egg floats inside and hits the eggshell when its shaken or jolted. Much like the egg yolk, your brain floats in cerebral spinal fluid within your skull. Today's helmet technology is advanced from its origins, but they still fail to prevent the brain from hitting the inside of the skull. Small steps like following your sport's rules, wearing equipment properly, avoiding to use the head as the primary point of contact or as a weapon, strengthening neck muscles to reduce whiplash probability and absorb forces may not prevent a concussion but could greatly decrease the chance of a concussion.

**Louisiana Youth Concussion Law (RS 40-1299.181) & Concussion Protocol(s):**
Louisiana requires specific steps for student-athletes participating in organized (ages 7-19 y/o) as it relates to concussion injuries

- Any student-athlete suspected of a concussion is removed from practice / game and evaluated by a licensed healthcare provider
- Student-athletes are required to have written medical clearance from a medical professional (MD, DO, NP, PA or Psych), preferably trained in the management of concussion to return to practice / games and complete a graduated return to full athletic participation
- Annual education and course completion requirement for public/private schools and rec leagues/clubs' athletes, parents, coaches, & officials

**When in doubt sit it out:**
The short-term and long-term effects of continuing to participate with concussion can be devastating. If a concussion is suspected, the student-athlete SHOULD NOT return to play or practice on that same day, as per LA Youth Concussion Law. The student-athlete should seek consultation from their licensed athletic trainer or healthcare provider. If your school's licensed athletic trainer isn't available, make sure to report to your team's coach or school nurse immediately. The long-term consequence of continuing to play through a concussion or returning too soon is Post-Concussive Syndrome. This results in long-term (often life-long) concussion symptoms.

The most serious risk of returning to play too soon is Second Impact Syndrome. Second Impact Syndrome is a severe condition that occurs when a student-athlete sustains a second blow to the head prior to the brain being fully recovered from the first concussion. Second Impact Syndrome is rare, but when it occurs, it is almost always fatal, resulting in death.

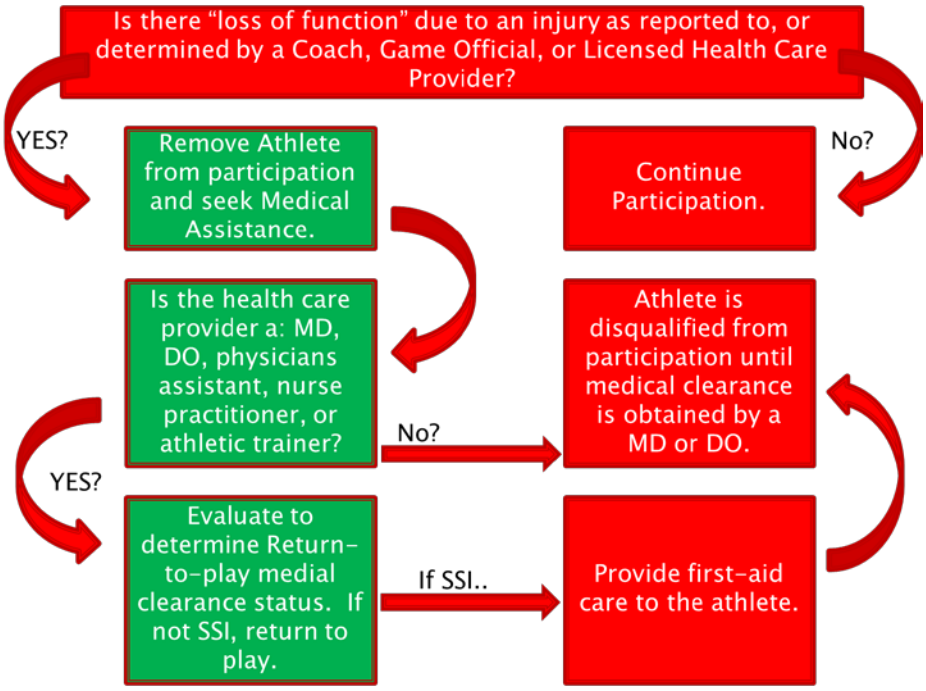
LOUISIANA ATHLETIC CARE

# Parent and Athlete Notification of the Risk of Serious Injury in Athletics

Pursuant to Act 352 of the 2011 Louisiana Legislative Session, before a student is allowed to participate in any school-sponsored or school sanctioned athletic activity, the student and parents or guardian of the student shall document they have viewed information provided in written or verifiable electronic form by the school regarding the risks of serious sports injuries.

By its very nature, competitive athletics can put students in situations in which SERIOUS, CATASTROPHIC, and perhaps FATAL accidents could occur. Students and parents/guardians must assess the risks involved in such participation and make their choice to participate in spite of those risks. NO amount of instruction, precaution or supervision will totally eliminate all risk of injury. Participation in athletics is inherently dangerous. The obligation of parents/guardians and students in making this choice to participate cannot be overstated.

*What happens when my child sustains a Serious Sport Injury?*




By granting permission to your son/daughter to participate in athletic competition through the LHSAA physical form and LAC Emergency Contact Form, a parent or guardian acknowledges that playing or practicing in any sport can be a dangerous activity involving many risks of injury. Both the athlete and parent/guardian must understand that the dangers and risks of playing or practicing to play include but are not limited to, death, complete or partial paralysis, brain damage, serious injury to virtually all internal organs, bones, joints, ligaments, muscles, tendons and other aspects of the skeletal system and the potential impairment to other aspects of the body, general health, and well being.

Because of the dangers of participating in sports, we (parent/guardian and player) recognize the importance of following instructions regarding playing techniques, training, equipment and other team rules, etc. both in competition and practice and agree to obey such instruction.

If any of the foregoing is not completely understood and you have questions, please contact your school's athletic trainer or athletic director for further information.

## Important Definitions

**Direct Injury** refers to an injury which results from participation in the fundamental skills of the sport. This may include, but not limited to, fractures, dislocations, injuries to the eyes, dental, or any other acute episode of musculoskeletal injury.

**Indirect Injury** refers to an injury caused by a systemic failure (usually cardiac or respiratory in nature) resulting from exertion while participating in an activity, or by a complication which may be secondary to a non-fatal injury. This may include, but not limited to, abnormal/difficulty in breathing, the appearance of dizziness or confusion or any other unusual behavior exhibited by a student-athlete.

**Loss of function** – Any sign of inability to perform any sport specific activity or movement. This may include, but not limited to, walking/running with a limp or holding/protecting a body part, or any other impaired movement.

**Responsible School Personnel** – The individual(s) (i.e., head coach, assistant coach, etc.) designated by the respective school with the responsibility for student-athlete safety.

**Return-to-Play (RTP)** – A term used to describe when a student-athlete, who has followed a step-wise protocol, is released to return to practice or competition.

**Appropriate Mid-Level Provider** – A health care provider duly authorized by a supervising MD/DO to provide care for sports injuries in accordance with their respective scopes of practice. For the purpose of this injury management program, the following health care providers may function as an appropriate mid-level provider onsite at any school-sponsored or sanctioned athletic activity: an athletic trainer (AT) certified by LSBME to practice in Louisiana; physician assistant (PA) licensed to practice in Louisiana; a registered nurse practitioner licensed to practice in Louisiana.

LOUISIANA ATHLETIC CARE

ND PIONEERS

Last Revised April 2022

ATHLETE NAME: _____ Date of Birth: _____ Graduation Year: _____

School: _____ Sport(s): _____ Last 4 SSN: _____
(Required for LHSAA eligibility)

Address: _____

Primary Parent/Guard Name: _____ ☐Mom, ☐Dad, ☐Other: _____

Phone: _____ Email Address: _____

Secondary Parent/Guard Name: _____ ☐Mom, ☐Dad, ☐Other: _____

Phone: _____ Email Address: _____

Emergency Contact if above contacts can't be reached: _____ Phone: _____

Select One

☐ PRIVATE INSURANCE (NAME/ID#): _____

☐ MEDICAID (ID#): _____

☐ NO INSURANCE: I understand and agree that the Notre Dame HS of Acadia Parish and Louisiana Athletic Care will assume no responsibility whatsoever, if the student-athlete is uninsured, for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in extracurricular athletics._____(initial)

FAMILY PHYSICIAN/PCP:_____

**Medical History Please check all that apply:** Circulatory / Pulmonary Conditions_____ Diabetes_____ Asthma_____ Allergies_____

Concussion _____ Contacts/Glasses_____ Other_____ Current Meds(List)_____

If checked above please explain: _____

_____

***Parent or Legal Guardian please read the following:***

- I hereby give my permission to undergo medical treatment for any injury or illness that may be sustained or acquired during high school athletics by a licensed athletic trainer with Louisiana Athletic Care.
- I authorize the health care and educational providers of the above-named athlete to disclose medical and academic information to and receive information regarding the injury and treatment of named individual from the following representatives of Notre Dame HS of Acadia Parish: Athletic Director, Athletic Trainer, Team Physician, Treating/Consulting Physician, Team Coach, and Administrative Assistant to the Athletic Director for the purposes of treatment, prognosis, emergency care, injury record-keeping, gradual return to learn, and gradual return to play protocol(s).
- I understand that the licensed athletic trainer will perform only those procedures that are within their training, credentials, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries.
- I understand that if my son/daughter suffers a potentially life threatening injury or illness, and in the event that we [parent(s)/ guardian(s)] cannot be reached within a reasonable period of time, that I authorize any duly licensed medical practitioner to perform such procedures as may be medically necessary to alleviate the problem.
- I verify that I understand that my child may be injured while participating in any high school athletic practice or competition.
- I understand that it is possible that my child may sustain an injury which may result in permanent disability, paralysis, or possibly death.
- I understand that paralysis may include loss of movement, feeling, and use of his/her arms, legs, and trunk that may last a lifetime.
- I understand that it is my child's responsibility to adhere to all the rules and regulations of his/her chosen sport and that any infraction of these rules and regulations may result in injury to his/her opponent or his/herself. I also understand that no modification of protective equipment or uniform should be made.
- I understand that it is my child's responsibility to report faulty or poor fitting equipment immediately to the coach, equipment manager, or athletic trainer.
- I understand that all injuries and illnesses sustained by my child are to be reported to the athletic trainer.
- I have read, reviewed, and understand the Serious Sports Injury handout (printed and or digital format) regarding ACT 352 (LA R.S. 40:1299.181, et sequa) provided by Louisiana Athletic Care, LLC.
- I have read, reviewed, and understand the Concussion Solutions, LLC handout (printed and or digital format) regarding concussion management (LA R.S. 40:1299.181, et sequa) and education provided by Concussion Solutions, LLC.
- I hereby authorize the release of copies of all current and past medical records pertaining to my medical history, including all physical and athletic training records, diagnosis, treatment history, and prognosis of injuries from your personal knowledge and/or records to Louisiana Athletic Care's athletic trainers and medical staff(s). By my signature below I release Louisiana Athletic Care, LLC and above-mentioned school system from all liability which could relate to the release of such medical records and information.
- A photo copy of this authorization shall be deemed as effective and valid as the original.

**I do hereby certify that all the above information is true to the best of my knowledge and consent to the above:**

**Student-Athlete's Signature:** _____ **Date:** _____

**Parent/Guardian's Signature:** _____ **Date:** _____

Print student name (Last, First)_____