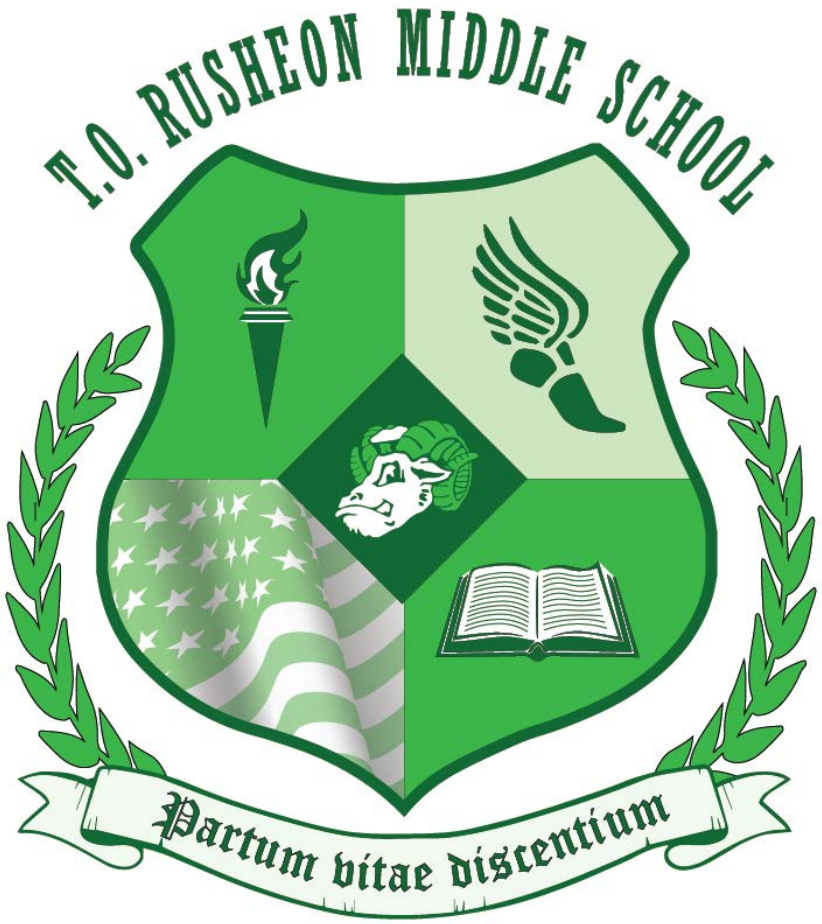
RUSHEON MIDDLE SCHOOL



ATHLETIC HANDBOOK and CONTACT

Athletic Department Mission Statement and Team Objectives

Rusheon Middle School strives to involve students and their parents in team building activities that contribute to a healthy, supportive, and interactive school culture at the middle school level. Membership on an athletic team offers a unique opportunity for personal growth, teamwork, and involvement in diverse activities. The attitude, behavior, dedication, and enthusiasm of the team members are just as important as the skills involved with being on the team. Members of the team must be committed to the highest level of athleticism, performance, self-discipline, respect, conduct, and all other responsibilities related to the pursuit of school athleticism, spirit, and pride.

It is recognized that these rules and procedures are necessary to maintain team morale, individual discipline, effective learning, fun, and safety. All members must realize that the manner in which they conduct themselves, in or out of uniform, directly affects the entire team and school.

It is our pledge to our students, teachers, parents, and community to organize, conduct, and maintain high quality teams at Rusheon Middle School. To support that goal, this contract has been created in order to communicate the athletic department guidelines and procedures. Please read the contract carefully and be sure to understand the rules and policies. All members of any Rusheon Middle School team will be held accountable for these rules and procedures.

Also understand, athletic team participation is a privilege and may be revoked by the coach or administrative team when rules and procedures are violated. If dismissal occurs, no money will be reimbursed at any time.

All athletic team members and coaches strive to:

- Provide leadership training
- Develop good decision-making skills
- Contribute to social development
- Maximize student growth opportunities
- Support RMS athletics and events in a positive light
- Encourage school spirit

Attendance Policy

Athletic team members are expected to attend all designated events. They are expected to be on time and completely prepared. Excessive absences will result in demerits or removal from the team. If you are going to be absent, please notify the coach as soon as possible. All appointments should be scheduled for non-athletic times. In the event of an appointment or an illness, please notify the coach and plan on a time to make up any missed practices.

Excused absences include but not limited to: illness (with a doctor note), family emergencies, special family events, other school sports or activities.

Unexcused absences include: illness (without a doctor note), failure to attend.

Academic and Eligibility Policy

Students' grades and academics will be monitored closely by Rusheon coaches, the athletic director, and the administration. It is expected that all team members maintain appropriate grades and behavior in the classroom. No athlete is to have an 'F' at anytime in any subject. If the student cannot keep his or her grades up, they may be put on academic probation or have to participate in tutoring before they can continue participating in athletic events. If a student is dismissed from a team or sport due to academic ineligibility, no money will be reimbursed.

Game/Game Day Guidelines, Rules, and Procedures

All policies and procedures for athletic groups are maintained in order to ensure the safety and well-being of all members involved. Failure to adhere to these policies may result in demerits or removal from the team.

1. No gum during games or practices.
2. No jewelry of any kind at games or practices.
3. Hair must be kept in a non-distracting, appropriate manner.
4. Students will report to the Gym (listen for announcements) on designated game days. Do not roam the school. Do not leave campus and return. You will be sent home.
5. Please come to school, on game days, dressed appropriately, in appropriate attire.
6. Uniforms, including shoes, should be neat and clean (if you need help with this, contact the coach).
7. Only bring sports drinks and water to drink.
8. Check in with your coach in the morning for attendance.
9. No excessive socializing during games or practices.
10. No excessive cell phone use during games or practices.
11. Demonstrate good sportsmanship at all times.
12. Perform only activities approved by the coach.
13. No leaving the bleachers, sidelines, or dugout without the coach's permission.
14. Only 2 team members may go to the restroom or concessions at a time unless noted by the coach.
15. Bring your own money for concessions. A light snack may be provided on game days but is not guaranteed.
16. No eating messy food or drinks while in uniform.
17. Students must ride the bus to and from the game unless special permission is approved by the coach and administration. Removing your child from the game may result in immediate removal from the team.

Transportation Rules

To ensure the safety and well-being of all team members, transportation will be put in place.

Students will ride to all events on the team school bus. Students will return to the RMS campus or given destination on the team school bus. Students will not be permitted to leave any event unless special permission is approved by the coach and the administration. This ensures the safety of all students. The best practice is to place on always picking your student up from school.

Students will only be released to parents, guardians, or family members at all athletic activities unless prior notice is given to the coach. If you would like any other person to be able to pick up your student, please list them on the form below. The designated pick up person must contact the coach. The coach will not be able to leave the event to find the designated pick up person in the parking lot.

Please understand that this policy ensures the safety of all members of the team.

Also, students will be notified close to the end of all practices, games, and events when to contact their parents for pick-up. Habitual late pick up will result in demerits. Please notify the coach as soon as possible if there will be any foreseeable transportation issues.

IN THE EVENT OF ANY TRANSPORTATION ISSUES, PLEASE CONTACT THE COACH IMMEDIATELY.

People Approved to Pick up my Student

NAME	RELATIONSHIP	PHONE NUMBER
1.		
2.		
3.		
4.		
5.		

Discipline / Demerit Guidelines

Members of all athletic teams are expected to follow all rules, procedures, and expectations at all times. When students do not follow these established rules, consequences are issued. The following sheet details all infractions and proposed consequences. Please remember, the coach or sponsor, athletic director, and all administration reserve the right to combine or skip demerit steps depending on the facts of each situation and the nature of the offense.

First Minor Offense – 1 demerit

Second Minor Offense – 2 demerits

Third or Higher Minor Offense – 5 demerits

Minor Offenses include (but not limited to): Uniform Violation, Minor School Disruption or Behavior Issue, Tardiness, Not Following Directions.

First Major Offense – 10 demerits

Second Major Offense – 20 demerits

Third or Higher Major Offense – 50 demerits

Major Offenses include (but not limited to): Referrals, Major School Disruption or Behavior Issue, Refusal to Perform, Lying.

If a student receives a total of 100 demerits, they are removed from the team. No money and/or items will be reimbursed or returned.

If a student is dismissed for any reason, no money will be reimbursed.

As a way to work off demerits, students may stay late after games and/or practices to work off their demerits. They may also come during appropriate school times such as PE (with permission) or break time. The coach reserves the right to determine when these appropriate times are available.

I understand the demerit policy for all athletic teams. I commit to doing my absolute best to avoid all demerits. I also understand that I have the ability to work off my demerits to avoid build up points.

_____	_____	_____
STUDENT SIGNATURE	PARENT SIGNATURE	DATE
_____	_____	_____
PRINT STUDENT NAME	PRINT PARENT NAME	PARENT CELL NUMBER

Rusheon Athletics Permission and Signature

I understand athletic participation involves risk to the participant. I further acknowledge that due to the nature of this physical activity, there is a possibility that my student may sustain illness or injury. I hereby accept this risk and release Rusheon Middle School from any claims of personal illness or injury.

I also understand that all athletic groups have established rules, regulations, and procedures pertaining to conduct, behavior, and activities of all group members by which we must abide by during participation in the activity. I am responsible for my own failure to abide by these rules and regulations.

I have read and agree to all of the rules, policies, and guidelines as outlines in the Athletic Group Contract. I understand the expectations of being a member of the team and commit to doing my absolute best at all times.

All athletic team rules will be interpreted and carries out by the RMS coach staff, under the guidance of the RMS Athletic Director and RMS Administration.

I have been provided a copy of the Athletic Group Contract and agree to participate in accordance with these expectations. By signing this form, I acknowledge that I have read and understand the athletic group expectations.

_____	_____	_____
STUDENT SIGNATURE	PARENT SIGNATURE	DATE
_____	_____	_____
PRINT STUDENT NAME	PRINT PARENT NAME	PARENT CELL NUMBER

OFFICE USE ONLY

Please sign all pages and return the entire packet.

_____	_____
RECEIVED ON	RECEIVED BY

Student Information Sheet

FULL NAME: _____ DATE OF BITH: _____

GRADE: _____ STUDENT ID: _____ GENDER: _____

PARENT/GUARDIAN NAMES: _____

ADDRESS: _____

EMAIL ADDRESS: _____

PHONE NUMBER(S): _____

HEIGHT: _____ WEIGHT: _____

EMERGENCY CONTACT #1

NAME: _____ RELATION: _____

PHONE NUMBER(S): _____

MAY THIS PERSON PICK UP YOUR STUDENT? YES NO

EMERGENCY CONTACT #2

NAME: _____ RELATION: _____

PHONE NUMBER(S): _____

MAY THIS PERSON PICK UP YOUR STUDENT? YES NO

PLEASE LIST ANY ALLERGIES OR HEALTH CONCERNS: _____

_____

SHIRT SIZE: _____ SHORTS SIZE: _____

ANY OTHER IMPORTANT INFORMATION THE COACH SHOULD BE AWARE OF? _____

_____

DATE OF LAST PHYSICAL: _____

ZURICH AMERICAN INSURANCE COMPANY

K12 - PROOF OF CLAIM – ACCIDENT MEDICAL EXPENSE

Mail/Email/Fax claims to:

K&K Insurance/Specialty Benefits
P. O. BOX 2338
Ft. Wayne, IN 46801
Fax: 312-381-9077 Toll Free: 800-237-2917
Email: kk.PAClaims@kandkinsurance.com

PART A

School District: Bossier Parish School Board	Name of School:
School Representative:	Title:
Phone Number ( )	
Email Address	

PART B

Date of Accident:	During: ☐ Practice ☐ Play ☐ Other (please describe)	
Time of Accident:	Type of Sport (if applicable)	
Describe the Accident:		
What part of the body was injured?	Which Side? (if applicable) R L	
At the time of the accident, was the injured person involved in an activity sponsored and supervised by the school?	Yes	No
Name of the Supervisor:	Was he / she a witness to the accident? Yes	No
Representative of school signature:	Date:	

Part C

Name of Claimant:		Social Security #	Date of Birth:	
Mailing Address: Street (Lot or Apt. No.)		City	State	Zip Code
Area Code + Home Telephone Number or Cell Number		Email Address		
Name of Father or Male Guardian	Place of Employment	Employer: Area Code + Phone Number		
Name of Mother or Female Guardian	Place of Employment	Employer: Area Code + Phone Number		
Is the injured person covered by other health and/or accident insurance plan? Yes	No	State Medicaid Yes	No	
Name of other health and/or accident insurance company	Area Code + Phone Number	Policy Number		
Where was student first treated?	Date of treatment:			

* **INCLUDE ITEMIZED BILLS FOR MEDICAL TREATMENT AND YOUR PRIMARY INSURANCE CARRIER(S) BENEFIT SUMMARIES (EOB'S)**

(AUTHORIZATION MUST BE COMPLETED BY CLAIMANT, OR PARENT OR GUARDIAN IF CLAIMANT IS A MINOR)

I AUTHORIZE any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance or reinsuring company, or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of claimant and any other non-medical information of claimant to give ZURICH AMERICAN INSURANCE COMPANY or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of this Authorization will be used by ZURICH AMERICAN INSURANCE COMPANY to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by ZURICH AMERICAN INSURANCE COMPANY to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request a copy of this Authorization. I AGREE that a photographic or photostatic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for the duration of the claim

Signature of Member, or Parent or Guardian if Claimant is a minor _____ Date _____

FRAUD STATEMENT

ALASKA: "A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law."

ARIZONA: "For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

ARKANSAS: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: "For your protection California law requires the following to appear on this form: Any person who knowingly present false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

COLORADO: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

DELAWARE: "Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

WASHINGTON D.C.: "WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim were provided by the applicant."

FLORIDA: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

IDAHO: "Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony."

I**NDIANA**: "A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony."

KENTUCKY: "Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

LOUISANA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

MAINE: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits."

MINNESOTA: "A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

NEW HAMPSHIRE: "Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20."

NEW JERSEY: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties." Substantially similar language must be approved by the DOI.

NEW MEXICO: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NEW YORK: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

OHIO: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

OKLAHOMA: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

OREGON: “I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact or material thereto commits a fraudulent insurance act which is a crime and such person may be guilty of insurance fraud.”

PENNSYLVANIA: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

TENNESSEE: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

TEXAS: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

VIRGINIA: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

WASHINGTON: "It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."

WEST VIRGINIA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Accident Medical Expense Benefit with Sublimits

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

Bossier Parish School Board Interscholastic Team Sports Coverage

SCHEDULE

Benefit	Maximum Benefit per **Insured** per **Covered Accident**	**Deductible** per **Insured** per **Covered Accident**	Co-Insurance: **Our** share of **Usual and Customary Expenses** per **Insured** per **Covered Accident**
Accident Medical	Class I: $50,000 Class II $5,000,000	Class I: $0 Class II: $50,000	Class I: 100% Class II: 100%
Benefit sublimits for the **Medically Necessary Covered Medical Service(s)** described below: **Applies to Class I and Class II Only:**			
1. Ancillary or Miscellaneous Inpatient Hospital	$5,000	$0	100%
2. Medical Emergency Care	$100	$0	100%
3. Outpatient Surgical Room (Includes Ambulatory Surgical Facility)	$1,000	$0	100%
4. Outpatient Diagnostic X-Rays and Laboratory Test	$750	$0	100%
5. **Physician's** non-surgical treatment	$250	$0	100%
6. **Physician's** Surgical Procedures	$5,000	$0	100%
7. Anesthesiologist	30% of the **Physician's** Surgical Procedures sublimit	$0	100%
8. Registered Nurse	$375	$0	100%
9. Physiotherapy	$500 (10 visit maximum)	$0	100%
10. Non-Emergency Inpatient/Outpatient X-Rays	$200	$0	100%
11. Diagnostic Imaging	$750	$0	100%

12. Ambulance Expenses	$1,000	$0	100%
13. Rehabilitative Limb Braces, Wheelchairs and other Medical Equipment/ Appliances	$2,500	$0	100%
14. Eyeglasses, Contacts or Hearing Aids	$1,000	$0	100%
15. Accident Dental	$4,000	$0	100%

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

LHSAA MEDICAL HISTORY EVALUATION/EVALUACIÓN HISTORIAL MÉDICO DE LHSAA

IMPORTANTE: Este formulario tiene que ser completado anualmente, archivado con la escuela, y estar sujeto a inspección por el Equipo de Reglas Cumplida.

Nombre:_____ Escuela:_____ Grado:_____ Fecha:_____

Deporte (s):_____ Sexo: M / F Fecha de nacimiento:_____ Edad:_____ Teléfono celular:_____

Dirección:_____ Ciudad:_____ Estado:____ Código postal:_____ Teléfono de casa:_____

Padres/ tutor:_____ Empleadores:_____ Teléfono del trabajo:_____

HISTORIAL MÉDICO FAMILIAR: Cualquier miembro de su familia menor de 50 años ha tenido estas condiciones?

Sí	No	Condición	Quien	Sí	No	Condición	Quien	Sí	No	Condición	Quien
☐	☐	Ataque al corazón, cardiopatía	_____	☐	☐	Muerte súbita	_____	☐	☐	Artritis	_____
☐	☐	Derrame cerebral	_____	☐	☐	Presión alta/hipertensión	_____	☐	☐	Enfermedad del riñón	_____
☐	☐	Diabetes	_____	☐	☐	Rasgo de células falciformes, Anemia	_____	☐	☐	Epilepsia	_____

HISTORIAL ORTOPÉDICA DEL ATLETA: ¿El atleta ha tenido cualquiera de las siguientes heridas?

Sí	No	Condición	Fecha	Sí	No	Condición	Fecha	Sí	No	Condición	Fecha
☐	☐	Lesiones de la cabeza / conmoción cerebral	____	☐	☐	Lesiones del cuello / Parestesias	_____	☐	☐	Hombro I / D	_____
☐	☐	Codo Izquierda / Derecha	_____	☐	☐	Brazo / muñeca / mano I / D	_____	☐	☐	Espalda	_____
☐	☐	Cadera I / D	_____	☐	☐	Muslo I / D	_____	☐	☐	Rodilla I / D	_____
☐	☐	Pierna I / D	_____	☐	☐	Periostitis crónica	_____	☐	☐	Tobillo I / D	_____
☐	☐	Pie I / D	_____	☐	☐	Tensión muscular severa	_____	☐	☐	Nervio comprimido	_____
☐	☐	Pecho	_____			Cirugías previas:	_____				

HISTORIAL MÉDICO DEL DEPORTISTA: ¿El atleta ha tenido cualquiera de las siguientes condiciones?

Sí	No	Condición	Sí	No	Condición	Sí	No	Condición
☐	☐	Murmullo en el Corazón / Dolor en el Pecho	☐	☐	Asma / prescrito inhalador	☐	☐	Irregularidades menstruales: último ciclo:_____
☐	☐	Convulsiones	☐	☐	Brevedad de la respiración / tos	☐	☐	Pérdida/ ganancia rápida de peso
☐	☐	Enfermedad del riñón	☐	☐	Hernia	☐	☐	Tomar suplementos/vitaminas
☐	☐	Latido cardíaco irregular	☐	☐	Inconsciente / conmoción cerebral	☐	☐	Problemas de calor
☐	☐	Testículo único	☐	☐	Enfermedades del corazón/cardiopatía	☐	☐	Mononucleosi recientes
☐	☐	Presión alta/hipertensión	☐	☐	Diabetes	☐	☐	Agrandamiento del bazo
☐	☐	Mareos / desmayos	☐	☐	Enfermedad del hígado/hepática	☐	☐	Rasgo de células falciformes, Anemia
☐	☐	Pérdida de órgano (riñón, bazo, etcetera)	☐	☐	Tuberculosis	☐	☐	Una noche de estancia (hospital)
☐	☐	Cirugía	☐	☐	Prescrito EPIPEN/Inyección de Epinefrina	☐	☐	Alergias (Alimentos, medicamentos)_____
☐	☐	Medicamentos_____						

Apunte las fechas de: La última vacuna de tétanos:_____ Vacuna de sarampión:_____Vacuna de meningitis: _____

FORMULARIO DE RENUNCIA DE LOS PADRES

Al mejor de nuestro conocimiento, hemos dado información verdadera y exacta y doy permiso para la evaluación del examen físico. Entendemos la evaluación consiste en un examen limitado y la investigación no se pretende ni evitará lesiones o la muerte súbita. Entiendo que si el examen es sin expectativa de pago, no habrá ninguna causa de acción en virtud de Luisiana R.S. 9:2798 contra el equipo voluntario de la salud médico o empleador bajo la ley de Louisiana.

1. Si, a juicio de un representante de la escuela, el nombre estudiante atleta necesita atención o tratamiento como resultado de una lesión o enfermedad, por la presente solicitud, consentimiento y autorizar para tal cuidado como puede ser juzgado necesario …… **Sí** **No**
2. Entiendo que si la condición médica de mi hijo cambia de cualquier manera significativa después de su examen físico, Notificaré a su principal el cambio inmediatamente …… **Sí** **No**
3. Doy mi permiso para que el entrenador le diga información sobre lesiones de mi hijo para el director de entrenadores/ Director/Director de su escuela …… **Sí** **No**

Esta renuncia, ejecutada el día _____ del mes _____, 20___, por _____ siguiente por el médico que suscribe, médico osteopático, enfermera o asistente médico y padre del atleta de estudiante nombrado arriba, que se realiza en cumplimiento de la ley de Louisiana con el completo entendimiento de que no habrá ninguna causa de acción por la pérdida o daños causados por cualquier acto u omisión relacionado con los servicios de atención médica si voluntariamente y sin expectativas de pago adjunto a menos que tal pérdida o daño fue causado por negligencia.

_____ **Fecha de firma de los padres**

_____ **Firma del padre**

_____ **Mecanografiado o en letra de molde**

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

COMPLETADO ANUALMENTE POR DOCTOR MÉDICO, DOCTOR OSTEOPÁTICO (DO), PRACTICANTE DE ENFERMERÍA (APRN) O ASISTENTE DE MÉDICO (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