Athlete's Name _____ **Date**_____
Age_____

PARENTAL CONSENT FORM FOR ATHLETICS - 2023-2024

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 sports 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 East Baton Rouge Parish School Board. I am also willing to abide by those rules as administered by the athletic association and the school staff.

I hereby give my consent for the above-named student to represent Mayfair Lab 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 an LHSAA Medical History (Physical) Form (This physical expires 13 months from the date it was signed and dated by the MD, DO, APRN, or PA). A copy of the physical exam will be good for all sports during the 2023-2024 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 PRACTIONER 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) 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 - 2023-2024

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, CAN NOT 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: _____

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

FOR more information:

cdc.gov/concussion

Signs Observed by Parents, Friends, Teachers, or Coaches

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

Concussion Danger Signs

One pupil larger than the other
A headache that gets worse
Repeated vomiting or nausea
Convulsions or seizures
Has unusual behavior
Is drowsy or cannot be awakened
Weakness, numbness, or decreased coordination
Slurred speech
Cannot recognize people or places
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 concussion s.

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 _____

FIELD TRIP PERMISSION FORM – 2023-2024

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 2023 to May 20, 2024. Mayfair Lab

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

Student Name (Please Print)	Student ID Number	School Name	
_____	_____	Mayfair Lab	
Parent or Legal Guardian Name (Please Print) _____	**Legal Relationship** ( ) Parent ( ) Foster Parent ( ) Legal Guardian	**Signature** _____	**Date** _____

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 East Baton Rouge Parish School Board, all medical records, information, facts, and particulars that 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 *annually*, kept on file with the school, and 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 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) or the associated medical personnel. ..... **Yes** **No**

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

Health Care Provider section on page 2

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

Name:_____ Date of Birth:_____ Age:_____ Date:_____
School:_____ Grade:_____ Sport(s):_____

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	☐	☐

ORTHOPAEDIC EXAM :

I. Spine / Neck

	Norm	Abnl
Cervical	☐	☐
Thoracic	☐	☐
Lumbar	☐	☐

II. Upper Extremity

	Norm	Abnl
Shoulder	☐	☐
Elbow	☐	☐
Hand / Fingers	☐	☐
Wrist	☐	☐

III. Lower Extremity

	Norm	Abn
Knee	☐	☐
Hip	☐	☐
Ankle	☐	☐

Health Care Provider notes (if needed):_____

[ ] Medically eligible for all sports without restriction

[ ] Medically eligible for certain sports_____

[ ] Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of _____

[ ] Not medically eligible pending further evaluation

[ ] Not medically eligible for any sports

This recommendation is from a limited screening.

_____	_____	_____
Printed Name of MD, DO, APRN or PA	**Signature of MD, DO, APRN or PA**	**Date of Medical Examination**

Revised 5/23 **This physical expires 13 months from the date it was signed and dated by the MD, DO, APRN or PA.**